Hon Andrew Little

Minister of Health
Minister Responsible for the GCSB
Minister Responsible for the NZSIS
Minister for Treaty of Waitangi Negotiations
Minister Responsible for Pike River Re-entry
Lead Coordination Minister for the Government's Response to the Royal Commission's Report into the Terrorist Attack on the Christchurch Mosques

4 July 2022

Harold.

Email: fyi-request-19134-f3cd2fc5@requests.fyi.org.nz
Ref: ALOIA186

Dear Harold

Response to your request for official information

Thank you for your request for information under the Official Information Act 1982 (the Act) to the Hon Andrew Little, Minister of Health on 19 April 2022, for a list of the following documents:

> *"1) Aide Mémoire: Update on New Zealand's Critical and Intensive Care COVID-19 Preparedness [17/09/2021]*
> *2) Aide Mémoire: Update on DHB COVID-19 Readiness [8/10/2021]*
> *3) Briefing: Enhancing national ICU capacity [22/10/2021]*
> *4) Memorandum: Deep Dive on care in community [10/11/2021]*
> *5) Briefing: Care in Community - Cabinet Paper for SWS [11/11/2021]*
> *6) Briefing: Cabinet Paper COVID-19 Care in the Community - health system readiness and preparation [1/12/2021]*
> *7) Aide Mémoire: Visit to Waikato District Health Board [16/12/2021]*
> *8) Briefing: Follow up from SWC on Care in Community paper [16/12/2021]*
> *9) Briefing: Talking points for Minister Little - Cabinet meeting on 25 January 2022- COVID-19 Care in the Community [21/01/2022]*
> *10) Briefing: Visit to NRHCC [1/02/2022]*
> *11) Aide Mémoire: COVID-19 Hospital Readiness [11/02/2022]*
> *12) Briefing: Proposal to resource additional critical care beds across Aotearoa New Zealand [28/02/2022]*
> *13) Briefing: Visit to Waikato District Health Board (Hamilton hospital) [21/03/2022]*
> *14) And finally, I would like to request copies of all Care in the Community Weekly Dashboards received by the minister since the beginning of March 2022."*

Copies of these briefings, aide-memoire and Care in the Community weekly dashboards are being released to you as attached and are outlined in Appendix 1 of this letter. Please note, where information is withheld under section 9 of the Act, I have considered the countervailing public interest in release in making this decision and consider that it does not outweigh the need to withhold at this time.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand
+64 4 817 8707 | a.little@ministers.govt.nz | beehive.govt.nz

Note the briefing that you have requested titled: "*Enhancing national ICU capacity"* was cancelled, therefore I am refusing this document under section 18(e) of the Act, as the information requested does not exist.

The document you have requested: *Briefing: Talking points for Minister Little - Cabinet meeting on 25 January 2022- COVID-19 Care in the Community (HR20220068)* is withheld in full under section 9(2)(g)(i) of the Act, to maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers and officers and employees of any public service agency.

I was unable to locate the memorandum: "*Deep Dive on care in community"* despite reasonable efforts to locate this paper. As such, this document is refused under 18(e) of the Act.

Under section 28(3) of the Act, you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

Yours sincerely

Hon Andrew Little MP
Minister of Health

Appendix 1: List of documents for release

#	Date	Document details	Decision on release
1	17 September 2021	Aide Mémoire: Update on New Zealand's Critical and Intensive Care COVID-19 Preparedness (HR20212076)	Released with some information withheld under 9(2)(a) of the Act to protect the privacy of natural persons.
2	8 October 2021	Aide Mémoire: Update on DHB COVID-19 Readiness (HR20212207)	
3	11 November 2021	Briefing: Care in Community - Cabinet Paper for SWS	Released in full.
4	1 December 2021	Briefing: Cabinet Paper COVID-19 Care in the Community - health system readiness and preparation (HR20212653)	Released with some information withheld under 9(2)(a) of the Act.
5	16 December 2021	Aide Mémoire: Visit to Waikato District Health Board. (HR20212734)	Released with some information withheld under the following sections of the Act: • 9(2)(a); • 9(2)(f)(iv); and • 9(2)(c) to avoid prejudice to protect the health or safety of the public.
6	16 December 2021	Briefing: Further information to support ‘Covid-19 Care in the Community – Health System Readiness and Preparation’ Cabinet paper (HR20212753)	Released with some information withheld under 9(2)(a) of the Act.
7	1 February 2022	Briefing: Visit to NRHCC (HR20220127)	
8	11 February 2022	Aide Mémoire: COVID-19 Hospital Readiness (HR20220205)	
9	28 February 2022	Briefing: Proposal to resource additional critical care beds across Aotearoa New Zealand (HR20220333)	

#	Date	Document details	Decision on release
10	21 March 2022	Briefing: Visit to Waikato District Health Board (Hamilton hospital) (HR20220505)	Released with some information withheld under the following sections of the Act: • 9(2)(a); • 9(2)(f)(iv); and • 9(2)(c)
11	20 March 2022 – 1 May 2022	Care in the Community Weekly Dashboards	Released in full.

Document 1

MINISTRY OF HEALTH
MANATŪ HAUORA

Aide-Mémoire

Update on New Zealand's Critical and Intensive Care COVID-19 Preparedness

Date due to MO:	17 September 2021	Action required by:	N/A
Security level:	IN-CONFIDENCE	Health Report number:	20212076
To:	Hon Andrew Little, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Robyn Shearer	Deputy Chief Executive, Sector Support and Infrastructure	S9(2)(a)
Andrew Connolly	Chief Medical Officer	

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Document 1

Update on New Zealand's Critical and Intensive Care COVID-19 Preparedness

Security level:	IN CONFIDENCE	**Date:**	17 September 2021
To:	Hon Andrew Little, Minister of Health		

Purpose of the report

1. This report provides an assessment of New Zealand's current Intensive Care Unit (ICU) and other critical care capacity and the ability to scale up capacity in response to a potential surge in COVID-19 cases.
2. The report then outlines steps being taken to establish a baseline of ICU capacity and capability to support New Zealand hospitals in confidently managing COVID-19 patients alongside BAU on an ongoing basis.
3. This includes an assessment of a recent report from Dr Craig Carr, a Dunedin ICU Intensivist and President of the New Zealand division of the Australian and New Zealand Intensive Care Society (ANZICS). His report considers ongoing requirement for ICU beds once New Zealand is 'opened up' and promotes investing in portable or modular ICU facilities, co-located near hospitals, to enable DHBs to maintain BAU services.

Summary

4. The New Zealand COVID-19 Alert Level Framework combined with the National Hospital COVID-19 Escalation Framework has supported New Zealand to prioritise and manage business as usual (BAU) work and COVID-19 patients at the individual DHB level and, to a lesser extent, at the regional and national level.
5. Work was completed in 2020 with DHBs on ICU planning for further COVID-19 surges following the initial Alert Level Four lockdown period. However, we have gained a great deal of new knowledge since then about COVID-19, including the new Delta strain and its increased risks, and from our response measures to date.
6. At the same time, planning is under way to determine what ICU capacity in necessary to support BAU and expected COVID-19 and other respiratory hospitalisations once New Zealand has a sustained high vaccination rate and moves away from level four lockdowns as its most effective tool for eliminating COVID-19 outbreaks.
7. In this context, the Ministry has commissioned new modelling to assist with strengthened critical care planning going forward.
8. A paper provided by Dr Craig Carr, includes suggested options for mobile, temporary COVID-19 dedicated critical care facilities. These options will be considered further in the context of the new modelling to be provided.

Current context

9. August 2021 modelling by the joint DHB and Health Infrastructure Unit's Critical Care

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Service Planning Project confirms New Zealand DHBs have a baseline of 243 fully resourced ICU capable beds in normal conditions.

10. Current daily SITREPs have DHBs self-reporting 320 available ICU capable beds. To achieve this increase, DHBs will be planning on using both fully trained and surge trained staff and reducing planned care activity.

11. As part of preparedness planning requirements, in mid-2020, DHBs identified that they could expand spaces and operate up to 553 ventilated ICU beds once sufficient surge staff were trained and non-acute hospital activity was minimised.

12. DHBs also identified that operating at that level for an extended period would put significant stress on staff and resources as they would also be managing large numbers of COVID-19 patients in respiratory units and medical wards.

13. The Delta strain means that New Zealand must stay highly prepared for a COVID-19 resurgence to avoid placing significant pressure on health services until current best practice infection control measures are supported by high vaccination coverage.

14. In addition, demands on the current workforce from Managed Isolation and Quarantine (MIQ), swabbing, vaccinating, staff self-isolation, and general stress have materially increased pressure on the health system's capability to sustain BAU and COVID-19 management in 2021.

15. While the current Auckland outbreak has overall been handled well by the DHBs, we have learned that more oversight is needed on DHB workforce preparedness, availability, and mobility, to provide assurance that sufficient ICU beds can be operated in a sustainable manner when and where needed under current conditions and going forward.

16. A range of independent experts have undertaken and released modelling on the number of hospital and ICU beds needed in New Zealand going forward. This is typically based on recent Australian information.

17. The variance in their forecasts around hospitalisations and ICU utilisation largely reflects assumptions about vaccination rates and infection control measures.

18. The Ministry has commissioned new COVID-19 modelling to identify ICU and other hospital and wider health system capacity necessary to manage any late 2021 surge event and to prepare for ongoing operation of the health system in a more open environment.

Review of Current ICU Capacity Including Workforce

ICU Physical Capacity 2020

19. There is no national database of ICUs, High Dependency Units (HDUs), or critical care units (CCUs) across New Zealand.

20. At the time of the 2020 COVID-19 outbreak, the Ministry was able to use data in the recently completed National Asset Management Plan to provide initial numbers, supplemented by data requests and information collated by ANZICS.

21. COVID-19 modelling at the time provided guidance on the expected maximum demand for ICU and HDU at a time when there was no vaccination available and the effectiveness of community control measures not well established

22. At the end of April 2020, DHBs reported they had 358 ICU capable beds available and

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Document 1

had agreed to continue training staff and preparing spaces to be able to surge up to 553 ICU beds if necessary.

23. The Ministry also directly purchased more ventilators, hi-flow nasal oxygen equipment, ICU supplies and started upgrading oxygen infrastructure as part of overall preparedness.

ICU Staffing Capability

24. A key ICU challenge is demand for nurses within ICU and HDU settings, given the ratio of specialist nurses to patients (1:1 and 1:2) respectively.

25. DHBs identified nurses with prior ICU experience and other nurses who could be trained to support a surge response. This includes Post Anaesthetic Care Unit (PACU) nurses, theatre nurses, surgical and medical ward nurses, emergency department nurses and anaesthetic technicians.

26. In addition to identifying and training additional nursing staff, DHBs also planned for team-based models of care with one ICU nurse overseeing a pod of non-ICU nurses and allied health professionals with ratios of experienced ICU nurse to patient varying between 1:2 and 1:5.

27. DHBs also proposed asking part time staff to work full time and change from 3 x 8 hour shifts to 2 x 12 hour. The DHBs noted this could only be sustainable for a short period of time (around two weeks) as staff would become fatigued.

28. Changes to ICU and HDU staffing models comes with recognised mortality risks due to patients needing close 1:1 monitoring, especially when coming off ventilation.

29. To support the proposed approach to increase ICU staffing capacity, the Ministry allocated $2 million of COVID-19 workforce funding to boost DHBs' ICU surge capacity by reimbursing DHBs for the costs of releasing staff for training and for the costs incurred by smaller DHBs when sending staff to larger DHBs for training.

30. To date, funding has been approved to train 1,220 people across New Zealand. DHBs have proposed to use this funding to undertake initial ICU surge training to increase the number of staff that can be utilised to boost ICU surge capacity and for refresher training for staff who have participated in the initial ICU surge training.

31. This funding has also been used to develop an e-learning programme. The NZ Critical Care Pandemic Relief Team Resource e-learning package component is designed for DHBs to undertake refresher training with those who have participated in the initial ICU surge training. The e-learning package was finalised and made available to all DHBs on 26 August 2021.

32. The availability of other medical staff is not considered as critical as nurses, as ICU specialists are able to be supported by anaesthetists and other medical staff who have relevant experience in theatres and CCUs.

33. In June 2021, DHBs reported they had 1,417 nurses fully trained to work in ICU and another 713 non-ICU nurses had received training in preparation for a surge in demand.

34. Additional focus is now being placed on increasing the ICU and HDU resilience of the large Auckland Metro DHBs as they are the centre of COVID-19 management, and scarce staff are being called upon to cover multiple roles.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

ICU Capability Going Forward

35. The various ICU planning projects operating across the Ministry were brought together in late 2020 into the joint DHB and Health Infrastructure Unit's Critical Care Service Planning Project.

36. A national critical care service plan will inform future infrastructure requirements over the next 10-15 years. The plan will describe the delivery framework for critical care services and provide a forecast of bed capacity required.

37. As modelling for COVID-19 is progressed, this will be incorporated into the service plan.

38. Importantly, this work has validated that DHBs have a baseline of only 243 fully resourced ICU capable beds.

39. Current daily SITREPs have DHBs self-reporting 320 available ICU capable beds across ICU and HDU, reflecting their plans to use both fully trained and surge trained staff and reducing planned care activity.

40. Based on the three Auckland metro DHBs' reported capacity of 131 ICU/HDU beds and around 60% utilisation, their August 2021 request for out of region ICU staffing support needs to be better understood in relation to their SITREP reporting.

41. The Ministry is working with the DHBs to ensure the daily reporting accurately reflects ICU and HDU beds that could be used for COVID-19 and excludes neonatal and paediatric intensive care beds.

42. The current Auckland outbreak has shown that more oversight and assurance is needed on DHB workforce preparedness, availability, and mobility, to provide assurance that sufficient ICU beds can be operated in a sustainable manner when and where needed under current conditions and going forward.

43. The Ministry is moving to ensure there is central visibility on the number of nurses now being actively trained and how they are being deployed through ICUs to get hands on experience to ensure that the numbers align with stated ICU capacity.

44. The Ministry has commissioned new COVID-19 modelling to take account of the new Delta variant context, up to date knowledge of the effectiveness of vaccination and lockdown measures and other lessons learned from New Zealand's COVID-19 response to date.

45. This will assist in identifying ICU and other hospital and wider health system capacity necessary to manage any late 2021 surge event and to prepare for ongoing operation of the health system in a more open environment.

46. This will include a review of the existing 553 ICU bed capacity forecast.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Review of Dr Carr's COVID-19 ICU Model, and Future Modelling

47. Dr Craig Carr has proposed commissioning external modular ICU capacity alongside hospitals that could be relocated as necessary and disposed of if no longer needed. He considers this would allow hospitals to then focus existing capacity on BAU requirements going forward.

48. His model presents a scenario where 90% of the population is fully vaccinated.

49. The model shows that 160 additional ICU beds are required if current public health measures were maintained to manage outbreaks and keep the prevalence of COVID-19 in the population at no more than 2 percent.

50. Significant additional ICU capacity would be required if no additional public health measures were put in place

51. The findings are consistent with another model recently presented to the Ministry by ICU specialists.

52. As can be seen from the current Delta outbreak, our hospitals are able to cope with a limited number of COVID-19 ICU hospitalisations, even when public health measures and adjusted alert levels are in place reducing overall hospital activity.

53. An outbreak in other regions, or multiple regions, would put additional strain on New Zealand's critical care system.

54. The Ministry is working with Te Pūnaha Matatini (TPM) to develop modelling that considers applicable measures and likely effects on ICU and hospital capacity to address reopening of borders.

55. Initial work and outputs from this modelling will be complete in time for inclusion in reports due to Ministers in October 2021.

Expansion of ICU Capacity within Hospital or as external Module

56. In the longer term, with a growing and aging population, New Zealand will need to increase in ICU and HDU capacity in a planned manner.

57. COVID-19 has heightened the focus on the optimal or essential level of ICU capacity needed by New Zealand, noting its expense and resource requirements.

58. To date, New Zealand has focused on increasing ICU capacity within existing hospitals, or through streaming services between COVID-19 designated acute hospitals and COVID-19-free planned care hospitals (potentially using private capacity for this purpose).

59. The Ministry considers external temporary facilities, as proposed by Dr Carr, should generally be undertaken as a final response, due to them needing to be integrated into a range of health services to support COVID-19 patients. There are also additional infrastructure complexities that would need to be addressed as part of any modular set up separate from existing hospital sites, for example ensuring reliable electricity and oxygen supplies.

60. The Ministry will provide further advice on these options, including a more detailed breakdown of the relative risk and benefits of the available infrastructure options, in October 2021.

Next Steps

61. The Ministry is actively working on a comprehensive work programme to ensure the health system can support New Zealanders to actively participate in the community and move more freely once high vaccination rates are achieved.

62. The programme will also consider what improvements, if any, need to be made to the

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

health system to ensure any future COVID-19 surges can be successfully managed with acceptable health outcomes, accounting for the current knowledge of the Delta variant and other lessons learned from our COVID-19 response to date.

63. Modelling is critical to these preparations, as is central planning, oversight, and deployment of staff.

64. While staff capability and leadership are critical determinants, the Ministry is continuing to review all ICU and HDU requirements to ensure key centres like Auckland are well prepared.

65. The Ministry will provide a further briefing to you in October 2021 with more detailed analysis of critical care needs in the current context and in a scenario of reduction in the current public health measures as New Zealand looks to re-open to the rest of the world.

Robyn Shearer
Deputy Chief Executive
Sector Support and Infrastructure
Date: 17 September 2021

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Document 2

MINISTRY OF HEALTH
MANATŪ HAUORA

Aide-Mémoire

Update on DHB COVID-19 Readiness

Date due to MO:	8 October 2021	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20212207
To:	Hon Andrew Little, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Martin Chadwick	Chief Allied Health Professions Officer	S9(2)(a)
Jess Smaling	Associate Deputy Director-General, DHB Performance and Support	

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Update on DHB COVID-19 Readiness

Security level:	IN CONFIDENCE	**Date:**	8 October 2021
To:	Hon Andrew Little, Minister of Health		

Purpose of the report

1. This report provides assurance of the work already undertaken and advice on next steps for district health boards (DHBs) to respond to any immediate resurgence and wider system resilience for when borders are relaxed.

Summary of DHB readiness plans

2. DHB readiness planning is a critical workstream in the overall Health System Readiness programme of work. The work in this area is longstanding, with DHB-led planning activity having been fast-tracked as part of the initial COVID-19 work in 2020.
3. DHB plans have been integrated over time based on local testing, and as we have collectively learned more about the management of COVID-19 in our communities and hospitals.
4. All DHBs have pandemic preparedness and resurgence plans to guide responses to community outbreaks and differing alert levels.
5. These plans sit alongside national frameworks that provide high level, nationally consistent guidance to support hospitals, facilities, and community providers to maintain as much service delivery as safely possible, during any COVID-19 resurgence.
6. Often when DHB planning is referred to, there is an assumption that this is primarily focused on our hospital and critical care settings. It is important to note that in our health system, our DHBs lead, commission and coordinate services across the health care continuum, from public health, through primary and community settings, and into specialist hospital care. DHB plans recognise this wider context.
7. While the approach h s differed across districts depending on local service configurations and pressures, broadly plans have covered:
    a. Emergency coordination
    b. Psychosocial coordination
    c. Clinical service delivery, including critical care
    d. Infection, prevention, and control
    e. Managed isolation and quarantine facilities
    f. Testing
    g. Equipment and clinical supplies.
    h. Primary and community care.
8. Within the primary and community care remit, plans include pharmacy, community residential care and aged care services, disability and home-based support services, NGOs, Māori and Pacific community providers, district nursing, community midwifery and allied health.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

9. Since the latest COVID-19 Delta variant outbreak, the DHB Chief Operating Officers (COOs) have established a working group to support rapid and practical review of policy development, advice and actively ensure hospital readiness.

10. The first priority of this group has been to develop a gap analysis of resurgence plans at a local level for both the community and hospital settings. This rapid review has identified gaps that DHBs have now been asked to validate to provide revised plans.

11. The key themes reported by the DHBs show:
    - All DHBs have articulated plans for ICU and Emergency Departments processes and service expansion in response to increased alert levels and demand.
    - All DHBs have plans to screen and stream patients based on risk factors.
    - Almost all DHBs articulated the intent for prioritisation/reprioritisation of surgery, planned care and outpatient services.
    - Planning around services to vulnerable people such as maternity, paediatrics, cancer care, mental health and assessment treatment and rehabilitation were not universally covered.
    - Implications for tertiary services such as neurosurgery, cardiac surgery, major trauma, burns, and spinal services need to be made more visible at a national level.

12. The approach has differed across districts depending on local service configuration and pressures.

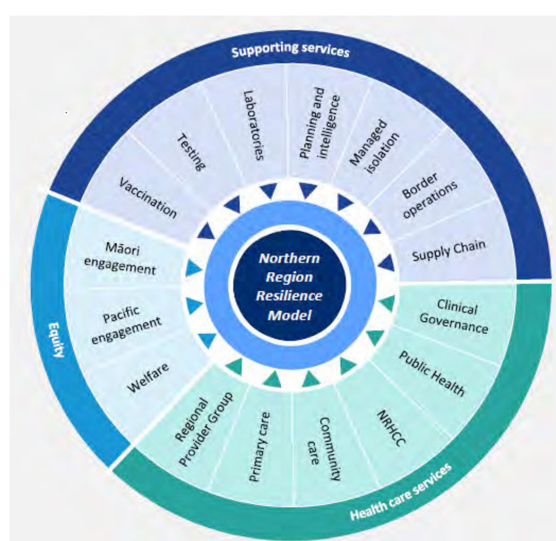
13. The lessons learned from the current outbreak are informing iterations of the plans, including how local, regional, and national responses are implemented.

Northern Region Resilience Plan

14. As a result of the recent Delta outbreak and the impact this has had on the Northern Region, and in particular, the three Auckland DHBs, the Northern Region DHBs are rapidly developing a Northern Region Resilience Plan.

15. This plan covers sixteen functional areas, from regional provider groups to community care and public health, supporting the services behind that and all aspects with an equity lens. Each function will be considered resilient if it has the capacity and capability to support sustainable responses recurring community resurgences of COVID-19, without limiting the ability to provide effective non-COVID related health care services

Image 1: Functional areas of Northern Region Resilience Plan



RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

16. The plan was presented to the National DHB Chief Executives at their meeting on 6 October 2021 and it was endorsed with agreement that their plan will be used as a template for the Te Manawa Taki, Central and Southern regions.

Next steps

17. Further work is underway to ensure consistency across DHB's local planning, and to make sure any interdependencies in terms of resources, capacity and workforce are acknowledged and appropriately planned for.

18. The template utilised by the Northern Region provides a platform for an all-region response. The COOs working group are working closely with the Ministry of Health Emergency Management group to support and enable a process to rapidly validate existing gaps and develop and test the plans where the gaps are identified.

19. There is also a need for national work to get a consistent view on prioritisation of health services should trade-offs need to be made between usual service delivery and management of COVID-19 patients.

20. The Ministry will provide you with regular updates on the wider Health System Readiness programme progress.

Martin Chadwick
Chief Allied Health Professions Officer
Office of the Chief Clinical Officers

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

In Confidence

Office of the Minister of Health and Office of the Minister for COVID-19 Response

Cabinet Social Wellbeing Committee

COVID-19 Care in the Community

Proposal

1 This paper outlines the evolving model of care for COVID-19 patients in the community, also referred to as 'COVID-19 care in the community' and explains next steps for scaling up the system.

2 This paper is designed to be read in conjunction with other papers prepared by the Ministry of Health and Ministry of Social Development that are on the Social Wellbeing Committee agenda on 17 November:

- COVID-19 Minimisation and Protection approach – changes to testing, case investigation and contact tracing (Minister for COVID-19 Response; Associate Minister of Health).
- COVID-19: A whole of system welfare approach under the COVID Protection Framework (Minister for Social Development and Employment).

Relation to government priorities

3 This paper supports the ongoing response to COVID-19 by setting out the current state and next steps for caring for COVID-19 patients in the community.

Executive Summary

4 This paper outlines the current state of the 'COVID-19 Care in the Community' operating framework, and highlights areas of development that are being rapidly scaled up and iteratively worked through to support the increasing number of cases.

5 New Zealand is now entering the next phase as we near a 90 percent vaccination rate across the country and we shift our Elimination Strategy to a minimisation and protection approach with the new COVID-19 Protection Framework [CAB-21-MIN-0421].

6 Under the new approach – and with increasing vaccination rates – many systems and processes which were designed with the goal of stamping out COVID-19 must now be adjusted to reflect the new goals of minimising the spread of COVID-19 in the community and protecting those most vulnerable to the disease.

7 This model will turn the patient experience on its head, from the moment they test positive with COVID-19. Where previously the initial response was a

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

public health one, focused on containment as the immediate priority, we now can make the response tailored to the individual's needs, starting with good clinical assessment, coupled with public health and welfare assessments. The Auckland region has already started to turn this model around; other regions will gradually do so, while maintaining a strong public health response to contain new cases quickly and efficiently.

8 Our model allows for home isolation of positive cases and contacts and is called the 'COVID-19 care in the community' model, as an alternative to managed isolation and quarantine (MIQ) for many people, with MIQ and other accommodation options remaining available for those who need them.

9 The COVID-19 care in the community model will operate as a high-trust framework that is centrally supported, regionally delivered, and locally led. The first iteration of the framework was provided to the health sector on 3 November 2021, and will be regularly updated based on feedback.

10 Central to this approach will be ensuring clinical health, public health, and welfare needs of a positive case, their whānau, household, and the wider community are better identified, and that necessary support is connected and coordinated. The model will help ensure the welfare of a positive case and others within the household, whilst limiting impacts on the wider health system and the workforce, and MIQ system capacity.

11 Ensuring that the model is addressing the needs of individuals and whānau in an equitable way is critical to its success, particularly given that the current outbreak is disproportionately affecting Māori and Pacific populations.

12 There will be significant financial investment needed to enable community health care providers to support COVID-19 patients as case numbers increase.

13 A more detailed update of the model, with updated financial implications and metrics for analysis, will be provided to Cabinet early in December 2021.

Background

14 In the New Zealand health system, both before and during the COVID-19 pandemic, most people are cared for at home when they are unwell, with support from primary, secondary, and tertiary health care as needed.

15 As New Zealand nears 90 percent vaccination rate across the country, our Elimination Strategy is shifting to a minimisation and protection approach. This will see us replacing the Alert Level Framework with the new COVID-19 Protection Framework (CPF) [CAB-21-MIN-0421].

16 The adoption of the CPF framework recognises that our approach to providing COVID-19 care in the community is changing. Under an Elimination Strategy, our goal was to eliminate transmission of COVID-19 within the community and MIQ was a key tool for achieving this. The transition to the CPF framework will

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

see a shift to using self-isolation and quarantine options both in the community and at the border.

17 This approach acknowledges that we are moving to a setting where, with a highly vaccinated population and the appropriate set of measures to protect vulnerable communities, identifying and isolating every case of COVID-19 in MIQ is not the best use of public health resource.

18 This does not mean that MIQ will not remain a part of the COVID-19 response toolbox. MIQ will remain necessary where managed care is appropriate, for example for those who cannot safely isolate at home but do not need hospital level care, but it will be used proportionately and as required rather than as the default. Further, the Minister for COVID-19 Response will bring forward a separate paper to Cabinet on 13 December 2021 concerning the future of MIQ. This paper will seek agreement to a business case for longer term investment in infrastructure and a workforce for MIQ.

19 The option of home isolation will also support our overall strategic direction of managing expected future COVID-19 waves and allowing us to move more freely domestically and open internationally without the impact on our health system becoming unmanageable.

20 Other critical pieces and complementary work includes the MSD-led welfare approach and the Housing and Urban Development (HUD) work in alternative accommodation solutions, which address key components of the COVID-19 care in the community model.

Turning the model on its head

21 Our model for caring for COVID-19 patients in the community must have elements that are nationally consistent, namely the notification, assessment, monitoring, and escalation pathways, with variation in the approach to meet individual needs including any welfare support.

22 At its core, caring for patients at home under this model is necessarily a high trust model, based on the principles of centrally guided, regionally coordinated, locally led, to efficiently allocate health resource and enable people to be cared for in the context of their community. This model does not replace hospital care where needed but is about providing the right care at the right place at the right time.

23 Using trusted points of contact, as far as is possible, is also vitally important that everywhere around New Zealand, people understand the support available to them and what is required of them if they test positive. Acknowledging the need for trusted contact points, the rules and process need to be simple to understand and navigate for diverse providers and populations across New Zealand. They need to be supported by their health and social services, but also by the wider community to do the right thing, and families, friends, and employers all need to continue our collective efforts.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

24 Work is underway with the Department of Prime Minister and Cabinet to develop channels and messages for the public.

First point of contact and assessment of needs following a notification of a positive COVID-19 case.

25 The priority principle where a positive case is identified is that their initial point of contact is often the most critical. This initial contact must be delivered if possible by a known, trusted or connected clinician (such as a general practitioner) or other community provider who best understands the needs of the individual and their whānau, and aid in communicating all the relevant information needed at this key part of the process.

26 The last 20 months have focused on outbreak control response, so first contact has until recently rightly been through the public health unit (PHU) to get into contact tracing and providing initial support. Critical to this is the assessment of the public health status (contacts, household contacts), followed by the assessment of the patient's clinical status (signs and symptoms), emergent welfare and social needs, within the first 24 hours. Information is also collected for household contacts and any other close contacts that may require testing and subsequent support [Table A refers].

Given the highly vaccinated population and an enduring presence of COVID-19, the focus is now on the individual clinical assessment, followed by the welfare and public health needs to identify those who need urgent clinical support.

27 The key elements for addressing the needs of a COVID-19 positive patient will need to cover:

I. A positive COVID-19 test is returned.

II. The laboratory result will be notified to the relevant PHU and regional coordination hub, and the person's GP or another primary care provider (for unenrolled people) and potentially other service providers, e.g. Māori and Pacific providers.

III. The person will be assessed by their GP or other health professional for their suitability to recover at home, and notify them to expect a call from public health for a public health assessment.

IV. The practitioner carrying out the assessment will notify the appropriate hub to arrange home care or other support, referral to MIQ or admission to hospital where applicable.

28 It will be critical that the person doing the initial assessment has access to all relevant information and is able to view linked data from general practice and other providers to ensure the assessment takes account of the patient's holistic needs.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Evolving model of care of COVID-19 cases under the CPF will see a greater emphasis being put on an initial clinical assessment.

29 As the focus moves away to protection under the CPF, the care in the community model will evolve to prioritise the initial clinical and holistic assessment.

30 Additionally, as cases requiring home isolation increase, it will be important to reserve our limited public health resource for health-related critical functions such as confirmation of positive cases. It is expected that providers, such as primary care, could conduct the initial needs assessment. This will require assurance that key assessment components are robust, regardless of who is undertaking assessment.

31 The Ministry is working with Māori and Pacific health providers to ensure assessments consider cultural needs and nuances at this important stage, and throughout the home isolation process.

32 The information collected during this assessment will be provided to the patient's preferred and trusted primary care provider where one is available.

Table A: Personal/clinical assessment

Initial clinical assessment of COVID-19 signs and symptoms	**Public health assessment**	**Clinical risk assessment for COVID-19 complications and management**	**Support and cultural needs assessment**
Initial assessment of current or emerging need for clinical support as per usual processes for public health requirements and statutory responsibilities	As per usual processes for public health requirements and statutory responsibilities	Health history and current medical needs	Suitability of accommodation, safety, security, and essential needs, whānau needs
Secure and stabilise		Identify primary and community care needs and relationships	
Determination of suitability of place Care coordination for whānau Set-up activities including essential supplies and technology			

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Timely and coordinated processes will ensure that appropriate care is provided to the individual and their household.

33 The assessment will consider clinical and holistic risk in terms of COVID-19 symptoms and any other complications. Patients and their household are referred to a care setting (eg home, community facility, MIQ, or hospital) depending on the holistic level of need, including any welfare safety considerations, and risk of complications [Table B refers]. Consistency in this

is necessary so that people in all parts of the country understand what is required of them.

34 To appropriately triage patients and households, coordination at a local and regional level is needed. For example, while a patient may not be safe to disclose that they are experiencing family violence and are therefore not safe to isolate at home, risks of this type may be identified through information sharing between providers including local Integrated Safety Response approaches.

35 Regional and local coordinators will work with the patient's preferred or regular primary care provider, where there is one and the provider accepts the responsibility of COVID-19 care for the patient. If this is not possible, the coordinator will work to find an alternative primary care provider. At any time in the process, it is possible for an individual's or household's care setting to be escalated – for example, where it becomes clear that a patient is not able to isolate safely at home due to concerns for their health or the health of those isolating in the household with them. Guidelines will be provided to support clinicians and other community providers engaging so that they can better determine it is no longer appropriate for the positive case to be cared for in the community.

Table B: Levels of care needed and appropriate care setting

	Level One	**Level Two**	**Level Three**
Clinical assessment	Asymptomatic or mild symptoms	Moderate symptoms	Severe symptoms requiring acute or palliative care
Risk of complications	Low risk (e.g., fit, young and healthy)	At risk of complications	-
Feasible care Setting	Home Quarantine	Home Quarantine	Hospital or Palliative care

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

COVID-19 care in the Community model

The COVID-19 Care in the Community model will provide support to COVID-19 cases and close contacts to isolate at home.

36 Isolation at home is a well-established part of the health system and an integral part of the evolving COVID-19 response.

37 The COVID-19 care in the community model sits within the wider Health System Preparedness Programme (HSPP) that is underway to ensure the health system is well prepared to manage an enduring presence of COVID-19 in the community.

38 International evidence and the experience in Auckland and Waikato have shown that whilst community cases will require management and monitoring of symptoms, most will not require admission to hospital. The clinical community is currently looking to experiences from Canada and Australia which indicate that a primary and community care-led response can reduce

pressure on hospital services, when supported with adequate clinical guidance, patient information system connections, equipment, and workforce. These lessons are being incorporated into the model outlined in this paper.

39 On 3 November, the Ministry released the first iteration of COVID-19 Care in the Community Operating Guidelines that looks to provide central support on the establishment of regionally delivered and locally led systems which provide both clinical and welfare and wellbeing support to people in the community.

40 Any COVID-19 positive patients and contacts whose needs are best met in an MIQ facility will continue to be transferred there, wherever possible. This is also the case in the event of an individual requiring hospital-level care, they will be transferred to hospital.

41 There is also the option for DHB supported isolation facilities for cases and higher-needs contacts who are assessed to self-isolate unsuccessfully and where transfer to a MIQ is not feasible or warranted. These facilities provide a small volume of alternative accommodation solutions (5-10 bubbles of accommodation).

Primary care services and networks are critical in providing monitoring support and other health care for patients.

42 Primary health care, including but not limited to general practice, is well placed to care for people in the community. This is their core business, and for many people, their general practice pharmacists, midwives, and other familiar practitioners are their preferred and trusted health professionals. The Ministry is working with these sectors to ensure that they can adapt their services as needed to care for people at home, often via telehealth.

43 These providers also may have a lead role in case management, depending on the circumstances of the person they are caring for. We need to ensure people's health needs are attended to, both in terms of experiencing illness from COVID 19, but also in terms of continued management of other health conditions – for example people may need support to collect repeat prescriptions or attend a scheduled pregnancy consultation.

44 While in most cases, the regular health and welfare checks would be done by the patient's or whānau's regular general practice, in some cases, this will not be possible, for example approximately 10 percent of COVID-19 cases in Auckland were not enrolled with a general practice.

45 Establishing pathways to support whānau who are disengaged from primary care to enrol and access primary care thus ensuring they receive appropriate clinical care while isolating at home, will be critical. In these situations, the DHB would lead the monitoring and connect with local and trusted providers who can provide support with cases.

46 The exact form of patient welfare checks will vary depending on the context and needs of the patient and whānau, which may be in-person, or via

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

telehealth or other virtual means. As we continue to roll out greater support in the community, we expect to be able to provide updated metrics to Cabinet on the different types of welfare checks being requested, and what further support, if any, is needed to scale up methods of engagement that best balance whānau and communities' needs with provider capacity constraints.

A nationally integrated platform is being developed for providers to share information

47 It is critical that information from key disparate systems is shared where possible. The current systems development has to date has focused on the Elimination Strategy and does not, on its own, fit the purpose for the CPF.

48 As a short-term tactical support for the evolving requirements, the current solutions are being adapted and this includes the National Contact Tracing (NCTS), National Border (NBS) and Border Clinical Management (BCMS) Systems. Health providers will be responsible for inputting their assessments of each patient into their relevant medical records. However, we need to be able to feed in the social and welfare information that can be used by relevant providers.

49 The Ministry is working on developing a national virtual health and telehealth solutions to integrate information on clinical and welfare needs for cases and whānau.

50 The system will build on existing mechanisms used by the COVID Technology Platform Programme (Vaccination, Borders, Testing and Contact Tracing) to provide us with assurance people who are self-isolating are being supported appropriately, through a whole-of-system approach.

51 A fit for purpose solution that supports requirements of Care in the Community and integrates across PHUs, primary health providers, secondary care (hospitals) and manaaki/welfare organisations is under development.

52 The Ministry is also working to explore options so that people who are isolating can be contacted via their preferred channels, for example through instant messaging services, to reach people more quickly and reduce the risk of non-response to check-ins. We will also update on this in our December repo t back.

53 It is also anticipated that the individualised and holistic assessment approach being developed based on our learnings from the current work in Auckland, Waikato and Northland will provide the basis for how agencies will 'check in' on status and compliance of those isolating at home and in the community.

Tailoring isolation support services at a regional and local level

54 We understand through our experiences in Auckland and Waikato that the likelihood of cases and contacts being willing and able to fully comply with isolation or quarantine arrangements is strongly influenced by the quality of the relationships that are established at the outset. It is important that upon

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

first contact with the COVID-19 positive person and their whānau, they are made to feel safe, respected and supported.

55 This underscores the importance of undertaking assessment of personal health and welfare needs as soon as possible. The programme is developing key metrics for this stage of the process; examples may include:

- The clinical assessment will happen within 24 hours of a returned positive test result (95% target)
- Care needs/referral to alternative accommodation within 48 hours
- Interview by public health within 72 hours.

56 Officials will brief Ministers on settled metrics early in December 2021.

Providing social, welfare, wellbeing, and cultural needs through the whole-of-system 'welfare approach'

57 The success of the clinical care is dependent on ensuring the holistic and wrap-around approach is taken to appropriately support the individual who is required to self-isolate.

58 It is critical within the initial hours following a positive COVID-19 result, to provide individuals who have high pre-existing needs with appropriate wrap-around support.

59 The Ministry of Social Development (MSD) is leading the development and provision of a whole of system approach that will provide welfare and community-based supports, including food and other essential wellbeing provisions to support individuals who are required to self-isolate and have immediate welfare needs.

60 The welfare system approach will ensure that where the initial assessment has identified that welfare support is required, the appropriate welfare agency or provider will be engaged to navigate and support critical wellbeing with urgency.

61 The principles of ensuring equity in individual and whānau experiences and enhancing their mana when engaging with services will guide the approach. We understand from Māori and Pacific providers supporting COVID-19 patients in Auckland that there needs to be a key point of contact for whānau to assist them to navigate the system and refer their needs out to appropriate providers as soon as possible, so that clinical and other care can be well-integrated.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Suitable accommodation will be critical to enable safe self-isolation under the whole of system welfare approach.

62 While most people who test positive and their immediate household will be able to safely isolate at home, some of our most vulnerable groups will need alternative options.

63 We intend that everyone is able to have appropriate accommodation that is suited to their needs and supports them to isolate safely.

64 The DHB supported isolation facilities could provide a small volume of alternative accommodation solutions. However, this is limited in scale, not available in all regions, and will not be able to meet anticipated increased demands. Table C represents accommodation units currently secured in place with a contract under the accommodation component of the care in community model. The Ministry of Health will continue to work with DHBs and MBIE to ensure sufficient supply of isolation facilities to meet the anticipated demand.

Table C: Accommodation units available across the country

DHB	Number of units
Northland	5
Auckland	7
Waikato	0
Bay of Plenty Lakes	13
Tairāwhiti	6
Hawke's Bay	10
Taranaki	6
Whanganui	5
Mid Central	5
Wairarapa	3
Capital and Coast Hutt Valley	4
Nelson Marlborough	9
West Coast	0
Canterbury	6
Southern	8
South Canterbury	0

65 HUD, Kāinga Ora, MBIE, and MSD are developing an accommodation response to support the Ministry of Health's implementation of home isolation and to complement the Welfare response.

66 Under the proposed approach, alternative accommodation would be needed for COVID-19 positive people who are in accommodation that is unsuitable for safe self-isolation, where a welfare response cannot manage risks of spreading the virus, and for COVID-19 patients who are non-compliant with self-isolation guidelines.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Management of ongoing health, social and welfare needs is critical post recovery of the patient.

67 The primary care team supporting the patient and whānau will continue to be responsible for regularly monitoring symptoms through the at-risk period of the illness (typically until day 14). Many people experience ongoing symptoms and their clinical care will be managed by their primary care team. If these continue at 6 weeks post-diagnosis, a follow up consultation will be used to consider whether they need to be referred for secondary care review or further support services for rehabilitation.

68 The roles and responsibilities need to be clear and understood and we still have work to do to fine tune the model.

Implementation considerations

DHB regional resilience plans will be used to implement and assess the progress of the 'COVID-19 care in the community' model.

69 As a result of the recent Delta outbreak and the impact this has had on the Northern Region, and in particular, the three Auckland DHBs, the Northern Region DHBs have developed a Northern Region Resilience Plan that provides a platform for an all-region response.

70 The plan covers sixteen functional areas, from regional provider groups to community care and public health, and all aspects have an equity lens, refer figure one.

71 Each of the four DHB regions has appointed executive leads for progressing the improvements of identified gaps. The leads meet regularly to progress regional preparedness and activities and is coordinated by the Health System Preparedness Programme (HSPP).

72 Each DHB region nationally has or is implementing a governance forum, a coordination function and dedicated resource to deliver their preparedness planning. Progress reporting against these plans is provided to the HSPP to ensure that learnings can be shared and any roadblocks can be removed or resolved in real time.

The Managing COVID-19 in the Community model will be reviewed regularly as we progress our learning from regions and communities across New Zealand.

73 While home isolation as a concept is not new, we consider that consistent improvement can be made to ensure that the system is working as intended for patients, whānau, and organisations supporting them. The compressed timeframes for implementing the CPF will require solutions that need to be adapted on the basis of the experience that follows, reflecting local conditions and needs.

74 The clinical operating model and guidance for care in the community are updated regularly, including further advice on best practice as this comes to

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

light. This means, for example, that key lessons from how home isolation has worked in Auckland and in the Waikato can be used to support effective home isolation throughout the rest of New Zealand, should this become necessary. Copies of the operating model can be made available to Ministers on request.

75 The improvements will be underpinned by rigorous risk assessment and effective information sharing between providers to ensure that those isolating have their needs met and are able to access care appropriate to their holistic level of need. The regional planning is also critical in providing oversight of the challenges and achievements within regions that will be considered as part of the continuous learning and improvement process.

76 There are particular complexities around supporting COVID-19 patients who have other pre-existing conditions. The Ministry is working with relevant parts of the sector, such as the Royal New Zealand College of General Practitioners, to ensure that these complexities are considered when guidance is being developed and updated.

Interagency support and coordination at central, regional, and local level will be critical to ensure the success of this programme.

77 Interagency relationships that promote collaboration and coordination will be critical for the integration and connection of investments and services. This applies at all levels of support from centrally supported, regionally delivered, and locally led.

78 Effective regional coordination is necessary to safely manage each case and manage health system capacity so that resources can be delivered where they are most needed. Frameworks have been developed by Pacific health providers South Seas and The Fono in Auckland to assess patient and whanau needs, and these are being drawn on to support providers with culturally competent and appropriate clinical care.

79 PHUs are already building capacity to be able to cope with increasing case numbers and bringing onboard support via telehealth. However, other providers, particularly in primary care, will need to offer support in the assessment process to ensure patients are provided with appropriate support in timely manner. The Ministry is working on standardised, culturally appropriate assessment that can support diverse parts of the health workforce to conduct the assessment.

80 To manage COVID-19 positive people and whānau in the community, more rapid notification and involvement of primary care clinical teams is needed, and a more diverse workforce will be engaged or required. New roles and responsibilities may be shared across the system, such as more effectively including allied health workforces. Work is underway to streamline information sharing and to enable escalation of information to primary care teams where necessary.

81 Support is needed to empower and enable the workforce to be safe and effective in their roles, and to ensure sustainability. Flexibility of traditional

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

roles is encouraged, provided that the people engaged have the appropriate qualifications, competencies, and tools for their work. This includes community health pathways (developed in tandem with the primary care clinical model) for primary care teams to use at point of care for guidance on clinical management.

Metrics and standards are being developed to support the shift from a primarily public health response to an individual clinical assessment.

82 There are existing metrics for our public health response to COVID-19, for example requiring cases to be contact traced within the first 48 hours.

83 However, as we transition to a new approach, as stated in paragraph 55, new metrics have been developed and these will be further considered. The Ministry will report back on metrics under the new model as part of the December 2021 report back to the Cabinet, and iteratively up until then.

Financial Implications

84 There will be financial implications from the evolution of the model for care for 'COVID-19 care in the community'. However, the work to create an accurate picture of the funding required is yet to be completed.

85 Initial costings for community-based care assumes that clinical support for patients requiring low to moderate level care will be provided through a combination of general practice teams, established telehealth clinical services, pharmacy services, and ambulance services. Clinical care is anticipated to be available and accessible 24/7 to meet the needs of households. The costing also includes translation services to support clinical care and digital system integration for clinicians to access patient information. However, these costs are current best estimates only and the underpinning assumptions are currently under review with leaders from across the health sector. Costs for equipment, information technology, accommodation alternatives and MIQ are excluded from these costs, but will be covered in other relevant Cabinet papers.

86 More complex care in the community will require a multidisciplinary team clinical approach that will not only draw upon primary care clinical resources, but will also require specialist services, and DHB outreach clinical supports, delivered through the regional and local coordination functions. The costings for this are currently being worked up.

87 For the funding period 1 November 2021 to 31 October 2022, we anticipate approximate costs as set out Table D.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Table D: Initial cost estimates for community based care

Sector	Funding (millions)
General practice and established telehealth clinical services (telehealth/virtual assessments, monitoring, in-person assessment)	$420.826
Community pharmacy (medicines advice, medicines management and delivery)	$18.136
Paramedic and Ambulance services (patient transport)	$7.170
Translation services to support clinical care	tbc

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

88 While significant investment is required, providing care for patients and whānau at home is likely to be more cost-effective than caring for patients in MIQ or in hospital, and ensures that MIQ and hospital resources are reserved for patients and whānau with the most need.

89 We will return to Cabinet with detailed costings for the complete Health System Preparedness programme of work, including this aspect of COVID-19 Care in the Community early in December 2021.

Legislative Implications

90 This model operates in a high-trust environment where health is not involved in compliance.

91 The assessment upfront will identify people at risk of being unable to comply with the requirements of home isolation, and these people may be transferred to MIQ or other alternative accommodation.

92 We need a legal framework that will require people to stay at home and will also provide an escalation framework that will be used for most serious breaches, taking into account equity and considering diverse and often complex needs of individuals and communities.

93 Agencies are currently building the legislative and compliance frameworks for isolation at home. The legal and compliance approach will be based on an individual's status, that is, they are COVID-positive or a potential case (a community contact or a returnee), rather than creating a different framework for returnees as compared to community members in isolation because of previous location alone.

94 We anticipate that once we shift to the CPF, the requirement to isolate at home will be achieved through amendment to the Isolation and Quarantine Order rather than continuing the use of s70 Orders as we are now.

95 The compliance framework will consider the post-Elimination context and as appropriate, adopt a high-trust model. It is anticipated that this framework will take account of risk assessments of individuals and/or households, to determine the level and nature of checking that needs to be in place, and will create a clear pathway and mechanism for escalation (including trigger points)

for relevant providers and professionals to follow. Ensuring that communities retain trust in providers and professionals will also be a key factor in the design of the framework.

96 Agencies will provide an update to Ministers on this work in late November as part of the CPF report-back, including more details on the approach, the frameworks, health and welfare pathways and plans for communicating expectations to the public.

Impact Analysis

Regulatory Impact Statement

97 The identified potential legislative changes do not require a RIS because all Orders made under Section 11 of the COVID Act have a standing exemption from this process.

Climate Implications of Policy Assessment

98 Not required as it is not anticipated that the work set out in this paper would have significant emissions impacts.

Population Implications

99 Māori and Pacific inequities have worsened as a result of the current COVID-19 outbreak, impacting Māori access to a range of services and resources. Inequitable COVID-19 vaccination rates between Māori and other ethnicities means Māori are more vulnerable to contracting COVID-19. They are also at increased risk of severe COVID-related infections, hospitalisation, requiring ICU care, and death. It is critically important that care in the community is delivered in a culturally competent way to reduce additional health risks. This is being managed by collaborating with Māori and Pacific health providers to support patients most at-risk from COVID-19.

100 Māori and Pacific populations are also overrepresented among people with insecure or crowded housing, which may be unsuitable for home quarantine. Consequently, retaining options for people to be transferred to MIQ or other community isolation facilities is an important part of reducing inequities in this work programme. This is also likely to be important for people who are not safe at home, for example victims of family violence, who are more likely to be women.

101 For rural populations, home quarantine reduces the need to travel far from people's support networks; providing support by telehealth where available is likely to be beneficial to rural populations, although it will not always be possible (for example, in areas with poor phone or internet coverage).

102 There remains significant risk for disabled people - high mortality rates associated with COVID-19 infections are reported internationally. Significant distress has been reported by families under current level three restrictions and there is potential for these issues to be further exacerbated by community

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

isolation and quarantine. Ensuring accessibility of communications and support will be critical to supporting disabled people to isolate when needed. The lack of feeling safe is as relevant as being safe and will impact behaviours, in particular hesitancy in accessing COVID-19 testing. It is recommended that disabled people and their allies are engaged in a rapid design approach to ensure the issues for disabled people are understood and designed into the approach.

Human Rights

103 The changes outlined in this paper have no immediate impact on human rights, beyond those outlined in relation to the minimisation and protection approach [CAB-21-MIN-0421 refers].

Consultation

104 The following agencies were consulted on this paper: Department of Prime Minister and Cabinet, Ministry of Social Development, Ministry of Business, Innovation and Employment, the Treasury, Te Puni Kōkiri, Ministry for Pacific Peoples, Oranga Tamariki, Ministry of Education, Ministry of Housing and Urban Development, Ministry of Ethnic Communities, Office for Seniors, Office for Disability Issues, Kāinga Ora.

Communications

105 All-of-government communications in relation to the implementation of the COVID Protection Framework will be considered separately by Cabinet.

106 Some operational communications within the health system has already taken place to allow changes outlined in this paper to be implemented. This includes updating guidelines around the use of home isolation which have been distributed to DHBs, PHUs and other health providers.

Proactive Release

107 I intend to proactively release this paper and its associated minute within the standard 30 business days from the decision being made by Cabinet, with any appropriate redaction where information would have been withheld under the Official Information Act 1982.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Recommendations:

The Minister of Health recommends that the Committee:

1 **note** that the Ministry of Health has developed the COVID-19 care in the community model to support COVID-19 patients and their households and whānau to quarantine and isolate at home

2 **note** that this approach also acknowledges that we are moving to a setting where, with a highly vaccinated population, managing COVID-19 care in the community will become the default as we start living with COVID-19

3 **note** that changes to the model will fundamentally change the patient experience by moving to a holistic clinical and welfare assessment at the start of the process, alongside the public health response

4 **note** that caring for patients at home is necessarily a high trust model, based on the principles of centrally guided, regionally coordinated, locally led, to efficiently allocate health resource and enable people to be cared for in the context of their community and does not replace hospital care where required

5 **note** that assessment and triaging of patient and whānau clinical and social wellbeing needs alongside public health needs will be critical factors determining the success of the programme

6 **note** that the COVID-19 care in the community model will be managed iteratively, with clinical operating guidelines regularly updated to reflect best practice as new evidence comes to light

7 **note** that work is ongoing to address equity considerations in the home isolation programme, including alternative accommodation options

8 **note** that the Ministry will report back to Ministers on metrics in the community care model early in December

9 **agree** that Ministers will make final decisions on metrics in the community care

10 **note** that primary care providers, particularly Māori and Pacific health providers, are fulfilling a critical role in providing care that effectively meets the needs of COVID-19 patients and their whānau

11 **note** that significant financial investment is needed to enable community health care providers to support COVID-19 patients as case numbers increase

12 **note** key enablers for the care in the community model are still being developed, including interventions which address social, welfare, wellbeing and cultural needs. Related advice on accommodation, welfare, and MIQ is being provided to Cabinet

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

13 **direct** joint Ministers to report back to Cabinet early in December 2021 on the detailed financial implications of this programme

14 **note** that there are no implications for primary legislation anticipated, and work is ongoing on how a compliance framework can be established through secondary legislation

Authorised for lodgement

Hon Andrew Little
Minister of Health

Hon Chris Hipkins
Minister for COVID-19 Response

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Document 4

MINISTRY OF HEALTH
MANATŪ HAUORA

Health Report

Cabinet Paper: COVID-19 Care in the Community – health system readiness and preparation

Date due to MO:	1 December 2021	**Action required by:**	
Security level:	IN CONFIDENCE	**Health Report number:**	20212653
To:	Hon Andrew Little, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Robyn Shearer	Deputy Chief Executive, Sector Support and Infrastructure	S9(2)(a)
Russell Simpson	SRO Health System Preparedness Programme	

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Document 4

Cabinet Paper: COVID-19 Care in the Community – health system readiness and preparation

Security level:	IN CONFIDENCE	**Date:**	1 December 2021
To:	Hon Andrew Little, Minister of Health		

Purpose of report

1. This briefing attaches a draft of the COVID-19 Care in the Community – health system readiness and preparation Cabinet paper that has been prepared for the Social Wellbeing Committee on 15 December 2021.
2. In November, Cabinet directed Ministers to report back on next steps regarding COVID-19 Care in the Community, including further information on the model of care, metrics for the programme, and financial implications. [CAB-21-MIN-0492 refers].
3. This paper requires consultation with your Ministerial colleagues with any feedback by 8 December 2021.

Robyn Shearer
Acting Chief Executive
Ministry of Health
Date: 1/12/2021

Hon Andrew Little
Minister of Health
Date:

MINISTRY OF HEALTH
MANATŪ HAUORA

Appendix One: Cabinet Paper COVID-19 Care in the Community

Document 5

MINISTRY OF HEALTH
MANATŪ HAUORA

Aide-Mémoire

Visit to Waikato District Health Board

Date due to MO:	16 December 2021	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20212734
To:	Hon Andrew Little, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Robyn Shearer	Deputy Chief Executive, Sector Support and Infrastructure	S9(2)(a)
Jess Smaling	Associate Deputy Director-General, DHB Performance and Support	

Document 5

MINISTRY OF HEALTH
MANATŪ HAUORA

Aide-Mémoire

Visit to Waikato District Health Board

Date due:	16 December 2021		
To:	Hon Andrew Little, Minister of Health		
Security level:	IN CONFIDENCE	**Health Report number:**	20212734

Details of the visit:

Friday 17 December 2021

12.30pm to 1.45pm

Waikato District Health Board
Waiora Central Business District (CBD) Building
87 Alexandra Street
Hamilton

Organisation

Waikato District Health Board (DHB) serves a population of more than 425,000 and covers more than 21,000 km. It stretches from northern Coromandel to Mt Ruapehu in the south, and from Raglan on the west coast to Waihi on the east. 59 percent of the population is defined as living in urban areas, and 41 percent in rural areas. 23 percent of the population is Māori (compared to the national average of 16 percent).

Purpose of the visit:

On Friday 17 December 2021, you are visiting Waikato DHB to meet with frontline staff including the:

- team undertaking the health system preparedness for COVID-19 summer response
- IT and IMT teams involved in the cybersecurity incident management.

Comment:

You have several events scheduled throughout the day. You will be accompanied by local Members of Parliament and by a staff member from your office.

A draft run sheet is provided in Appendix One and Appendix Two identifies key people.

This aide-mémoire discloses all relevant information.

Robyn Shearer
Deputy Chief Executive
Sector Support and Infrastructure

Document 5

Briefing points to support your visit

1. This briefing will support your visit to Waikato DHB. The visit is an opportunity to observe and discuss the region's preparedness for a COVID-19 summer response, and the region's response to the cybersecurity incident.

2. This has been a challenging year for the DHB, with the ransomware attack, the COVID-19 Delta outbreak and the subsequent lockdown, the nurses and midwives strike and their third-tier restructure.

3. During the visit you may like to:

   a. *Thank the people you meet for their mahi and their resilience.*

Waikato District Health Board

4. Dame Karen Poutasi has been Commissioner at the DHB since May 2019, when then Minister of Health, Hon Dr David Clark, ordered the replacement of the Board. Dame Karen works with two Deputy Commissioners, Chad Paraone and Emeritus Professor Margaret Wilson. Mr. Ken Whelan was appointed to the role of Crown Monitor at Waikato DHB in August 2018, and the appointment was extended in February 2021 to an open-ended term.

5. In the five months to 30 November 2021, the DHB reported a surplus of $0.9 million compared to its planned year to date deficit of $7.6 million. The underlying results net of COVID-19 related surpluses and other exceptional expenditure is a deficit of $5.9 million, which is $1.7 million favourable to plan. The draft (unaudited) actual 2020/21 result (excluding one-off costs) is a $28.4 million deficit.

6. Five capital projects have approved crown funding of $111.0 million and $14.9 million funding is contributed by the DHB. Two of the projects are classified S9(2)(f)(iv) and no action is required. Three of the projects are classified as S9(2)(f)(iv) by the Health Infrastructure Unit and risk mitigations are in place.

7. The Waikato DHB 2021/22 Annual Plan was signed by joint Ministers on 30 September 2021.

8. The DHB has been part of the Ministry of Health's (the Ministry) Intensive Support Programme since April 2021 and is progressing an intensive support plan which covers the following areas:

   - Mental Health and Addictions Implementation programme in response to the recently completed 'Waikato Mental Health and Addictions System Review'.
   - Reduction of child and adolescent mental health services waiting times.
   - Financial sustainability initiatives.
   - Development of more community and primary care services.

Health System Preparedness for COVID-19 Summer Response

9. Significant work has been undertaken by the health sector to prepare for a surge response to COVID-19 and implement the Care in the Community model. This includes DHBs undertaking preparedness plans, regional planning to share skills and resources,

and how to coordinate responses. This planning will ensure the country can coordinate its response to minimise risk and allocate resources to the right place, at the right time.

10. The Ministry has completed six desktop reviews of DHB resurgence plans, with another four reviews underway this week, including Waikato DHB. The level of engagement and cooperation with the review has been outstanding.

11. The aim of the review is to identify areas of concern for the DHB, to understand the plan's strengths, and to identify innovative practices to share with other DHBs. There is also an opportunity to highlight any additional areas for the DHB to focus their attention.

12. Waikato DHB has built a vast amount of experience to effectively respond to COVID-19 within their region, both at the community and hospital level.

13. There will be the opportunity to thank the Waikato team for their work and for their participation in the review hosted by the Ministry. You may also wish to ask the following:

    a. *What are the challenges and opportunities in supporting their communities? Specifically, what is working well, what could be working better, are there any examples of best practice that they would like to share, and what do they need from the Ministry/Government to support this work?*

    b. *What are the key things that have been learnt and what has been done to respond to/address these learnings?*

    c. *How well are they supporting vulnerable groups in their community?*

    d. *Are they happy with the strength of their preparedness planning?*

COVID-19 update

14. As of 14 December 2021, Waikato DHB reports[1]:

    a. 21 new cases confirmed in the Waikato overnight, with 11 in Te Kūiti, three in Tokoroa, two in Ōtorohanga, two in Hamilton, one in Te Awamutu, one in Taumarunui and one in Huntly

    b. there are 588 total number of cases (113 active and 475 recovered)

    c. two confirmed cases in hospital

    d. Public Health, primary care and manaaki providers are supporting 74 people to isolate at home

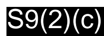
    e. 1,393 tests were processed on 13 December and 1,291 vaccinations given

    f. 93 percent of the eligible population have received the first dose of vaccine (86 percent Māori, 94 percent Pacific peoples), and 88 percent are fully vaccinated (75 percent Māori, 87 percent Pacific peoples)[2].

[1] **Information sourced from Waikato District Health Board website**
https://www.waikatodhbnewsroom.co.nz/2021/12/14/covid-19-public-advisory-14-december-2021/

[2] **Vaccination rates at Territorial local authority as at 11.59pm 13 December 2021.** https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-vaccine-data

Document 5



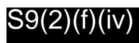
COVID-19 response, S9(2)(c), and clinical services

20. Waikato DHB reports that even though elective and outpatient clinics are now at full-service levels, they are working on addressing the backlog S9(2)(c) there will be an on-going impact on services and staff.

21. Despite the impact of COVID-19, Waikato DHB's total planned care interventions delivery for the year is at 99.3 percent of plan, however, inpatient surgical discharges are at 91.1 percent of plan.

22. The DHB has reduced their cardiac waiting list from 95 patients waiting in the week ending 15 August 2021, to 52 patients waiting in the week ending 12 December 2021. The maximum target waiting is 73 patients for Waikato DHB, and they have successfully managed the list.

END.



S9(2)(f)(iv)

Document 5

Appendix Two: Key Contacts

Key Contacts	Role
Dame Karen Poutasi	Commissioner
Chris Lowry	Executive Director Hospital and Community Service
Jade Sewell	Operations Director Community and Rural Health,
Maree Munro	COVID-19 Operations Director
Margaret Fisher	Chief Medical Officer Secondary and Tertiary
Julia Carr	Chief Medical Officer Primary Care
Debi Whitham	COVID-19 Directorate Service Delivery Manager
Liz Elliott	COVID-19 Directorate Testing Lead
Riana Manuel	CEO Te korowai Hauora o Hauraki (primary health)
Tamati Peni	Director Pacific Health
Jade Tamatea	Specialist, Endocrinology
Leaupepe Rachel Karalus	CEO K'aute Pasfika
Graham Guy	Operations Director for Medicine and OPR
Ingrid ter Beek	Director Supply Chain
Alex Gordon	Operations Director Cancer and Regional Medical Services
Sue Hayward	Chief Nursing and Midwifery Officer
Melinda Ch'Ng	Director Clinical and Operational Support
Nick Wilson	Director of Communications,
Kim Holt	Surgical Nursing Director
Marc ter Beek	Recovery Executive
Kay Stockman	Laboratory Service Manager
Andy Lee	IS Customer Service Coordinator
Garry Johnston	Manager IS
Kent Holdsworth	Director Integrated Operations Centre

Document 5

Trevor Ecclestone	Manager Emergency Management Planning
Alex Gordon	Operations Director, Cancer Services and Radiology
Alana Ewe-Snow	Manager, Funding and Provider Relations
John Deane	Applications Manager
Max Christopher	Platform Manager
Community and Māori providers	

Briefing

Further information to support 'Covid-19 Care in the Community – Health System Readiness and Preparation' Cabinet paper

Date due to MO:	16 December 2021	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20212753
To:	Hon Andrew Little, Minister of Health		

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Contact for telephone discussion

Name	Position	Telephone
Russell Simpson	Senior Responsible Officer, Health System Preparedness Programme	S9(2)(a)
Robyn Shearer	Deputy Chief Executive, Sector Support and Infrastructure	

Minister's office to complete:

☐ Approved	☐ Decline	☐ Noted
☐ Needs change	☐ Seen	☐ Overtaken by events
☐ See Minister's Notes	☐ Withdrawn	

Comment

Document 6

Further information to support 'Covid-19 Care in the Community – Health System Readiness and Preparation' Cabinet paper

Security level:	IN CONFIDENCE	**Date:**	16 December 2021
To:	Hon Andrew Little, Minister of Health		

Purpose of report

1. The purpose of this report is to provide an update on work towards the COVID-19 Care in the Community model, including funding options, further information on reporting and metrics, patient privacy and information sharing, and next steps on the housing and accommodation response.
2. This report discloses all relevant information and implications.

Summary

3. The Cabinet paper 'Covid-19 Care in the Community – Health System Readiness and Preparation' was discussed at the Social Wellbeing Committee on 15 December.
4. The purpose of the paper was to provide an update on the COVID-19 Care in the Community model. It also sought decisions on funding and financial implications and approval of metrics for the model.
5. We are seeking your decision on rates to be paid to enable general practice and other primary care providers to providing clinical care to COVID-19 positive patients while they are isolating home We consider that the appropriate pay rate would incentivise providers to participate in COVID-19 care in the community, while managing financial risk.
6. Reporting on metrics for Care in the Community is being developed iteratively; we will have confidence that there is robust data on all metrics by the end of January 2022. Until that time, reporting on metrics as they become available will continue to happen through daily Situational Reporting.
7. Patient privacy and information sharing must be carefully balanced to protect public health and maintain trust in the system. Consent to share patient information is done when a positive test is returned; we do not consider that it is a good use of health system resource to seek consent to share information prior to a positive test being returned.
8. All agencies that are involved in the COVID-19 Care in the Community model have a role to play in identifying and addressing housing needs. The specific roles, responsibilities, accountabilities and funding streams around housing are continually being developed as

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

part of the COVID-19 Care in the Community model. This work is progressing but is not yet at the stage where it can be provided in detail in the current Cabinet paper.

Recommendations

We recommend you:

1 **Agree** to one of the following funding options for primary care providers providing COVID-19 care in the community:

a) funding of $241.60 per hour. **Not recommended** **Yes/No**

OR

b) funding of $250 per hour. **This is the Ministry's preferred option.** **Yes/No**

2 **Note** that as soon as possible, the Ministry will transition from an hourly rate system to one in which available funding is grouped into packages of care that will incentivise providers to deliver clinical care in a way that meets the needs of both the patient and their whānau.

3 **Note** that financial implications the attached Cabinet paper have been updated to reflect the Ministry's preferred option, and that officials will update this if you choose another funding level.

4 **Note** that work is ongoing to integrate data sou ces so that reliable metrics will be available by late January 2022.

5 **Note** that we do not intend to seek consent to share information with providers of other services that the pat ent may need at the point of seeking a COVID-19 test.

6 **Note** that the Ministry is continuing to work with housing agencies to confirm roles and responsibilities for housing and accommodation in relation to Care in the Community, and that we will keep you updated on this work.

Robyn Shearer
Deputy Chief Executive
Sector Support and Infrastructure
Date:

Hon Andrew Little
Minister of Health
Date:

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Document 6

Further information to support 'Covid-19 Care in the Community – Health System Readiness and Preparation' Cabinet paper

Background

9. The paper 'COVID-19 Care in the Community – health system readiness and preparation' was discussed at the Social Wellbeing Committee's (SWC) meeting on 15 December 2021. This paper provides an update on the COVID-19 Care in the Community model. It also seeks decisions on funding and financial implications and approval of metrics for the model.

10. Your office has advised that SWC was not supportive of the proposed hourly rate to remunerate GPs for providing services to COVID-19 patients. The Ministry will work with the Treasury to agree on a revised hourly remuneration rate.

11. Further minor changes have been made to the paper and an updated version of the paper is attached as Appendix One. This version will be considered by Cabinet on 20 December 2021.

12. Where further changes have not been able to be incorporated into the Cabinet paper, an explanation is provided below.

Response to further feedback on Cabinet paper

Reporting against metrics

13. As noted in the Cabinet paper, metrics are proposed that cover all parts of the patient's journey, from positive test through to discharge from isolation and any follow-up care. Reporting on ome of these metrics is already occurring in the daily COVID-19 Situational Report to Ministers; for the remainder, a dashboard is being developed that will be used to report fully at the end of January 2022.

14. Providing well-coordinated care to patients and whānau will be digitally enabled through an updated case management system, adapted from the existing National Contact Tracing, National Border, and Border Clinical Management Systems, which will be able to include inputs from primary and secondary health, as well as social and welfare information.

15. Reporting of the metrics at a national level is dependent on DHBs, PHUs, general practice and providers using the Border Clinical Management System (BCMS) or directly through the integration of their patient management systems. Onboarding of DHBs and PHUs to BCMS is currently under way. Onboarding of DHBs and PHUs to BCMS is currently under way. Once onboarding and integration is completed, work will need to

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

be undertaken to guarantee the quality of the data before all metrics can be reported. This work will be completed by the end of January 2022.

16. We could investigate options for DHBs, PHUs and providers to report manually in the interim, however, it may not be the best use of Ministry and sector resources at a busy time of year, and we could not guarantee the quality of the data.

17. If we can report on any metrics sooner, they will be incorporated into the Situational Report.

Consent to share health information with other providers

18. We do not intend to seek consent to share information with providers of other services that the patient may need at the point of seeking a COVID-19 test. The rates of testing far outstrip the number of positive COVID-19 cases. It would not be an effec ive use of limited health resources to obtain consent from every person who has a COVID-19 test. In addition, some forms of testing are now self-administered such as mandatory saliva testing for border workers.

19. As outlined in the COVID-19 Care in the Community Framework, the notification of a positive COVID-19 case result will be sent to the public health unit (PHU) and the primary care provider that the patient is enrolled with (if they are enrolled with one) directly from the laboratory as a matter of course.

20. As soon as possible when a patient has tested positive for COVID-19, their point of contact in the health system will seek informed consent to share relevant information with providers of other services that the patient may need (for example, a GP sharing information about a patient's welfare needs with a social services provider).

21. Where people do not consent to have their welfare information shared, they are advised that they can call the relevant helpline to access support at any time. This is live now and has been in use since 9 December 2021.

At what point is patient privacy overridden to protect public health?

22. The PHU or other appropriate provider at the care coordination hub will assess a COVID-19 positive person's situation and the reasons why they are uncontactable or have not consented to their information being shared. If there are concerns about the person's health and welfare, the PHU will make a decision to share their information with another provider, the Finder service[1], or even escalate to Police in some circumstances.

Housing arrangements

23. All agencies that are involved in the COVID-19 Care in the Community model have a role to play in identifying and addressing housing needs. For example, the health sector will

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

[1] The Finder Service is a part of the National Contact Tracing Solution, with the purpose of finding contact details for cases and disease contacts within NCTS, for any NCTS users working on cases or high priority contacts. In order to do this, Finders liaise with a number of external and internal sources of information, such as Customs, GP practices, Police and IRD, as well as the Audit and Compliance team within the Ministry, providing as much detail as has been gathered by case investigators or contact tracers as necessary.

be well-placed to identify housing needs as part of the patient and close contact assessment process, while the Ministry for Social Development and Kāinga Ora are best placed to procure and place people in homes.

24. Pragmatically, it is also likely that patients and their whānau will also play a role in meeting their own housing needs and will not need support to do so (eg, some household members temporarily relocating to other premises to create space for patients to self-isolate safely).

25. The specific roles, responsibilities, accountabilities and funding streams around housing are continuing to be developed as part of the COVID-19 Care in the Community model. This work is progressing but is not yet at the stage where it can be provided in detail in the current Cabinet paper.

26. The Ministry has proposed an interim solution over the summer months, particularly in relation to regions that are likely to have a high number of visitors. There is a small amount of funding (approximately $14 million) in the community self-isolation and quarantine funding pool that that we propose could be repurposed to support DHBs with securing alternative accommodation over the summer months.

Next steps

27. Officials can provide further information on these matters at your request.

28. Note that you will be providing a report back to Cabinet in late February - early March 2022 on the Health System Preparedness Programme, including winter planning at which time any residual funding needs (including workforce needs) will have been more fully assessed and will be included. Health infrastructure funding is also being sought separately.

ENDS.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Meeting advice: Minister Little, South Seas, and Northern Regional Health Coordination Centre

Date due to MO:	01 February 2022	**Action required by:**	<N/A>
Security level:	IN CONFIDENCE	**Health Report number:**	20220127
To:	Hon. Andrew Little, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Robyn Shearer	Deputy Chief Executive, Sector Support and Infrastructure	S9(2)(a)
Geoff Gwynn	Programme Director, Health System Preparedness	

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Document 7

Meeting advice: Minister Little, South Seas, and Northern Regional Health Coordination Centre

Security level:	IN CONFIDENCE	**Date:**	01 February 2022
To:	Hon Andrew Little, Minister of Health		

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Purpose of report

1. This report provides you with information for your meeting with Souths Seas and the Northern Regional Health Coordination Centre (NRHCC) on 2 February 2022.
2. This report discloses all relevant information.

Summary

3. On Wednesday 2 February 2022, you are meeting with South Seas and the NRHCC. This meeting will take place on site at the Pacific and Māori Co-ordination Hubs, 31 Highbrook Drive, East Tamaki, Auckland.
4. The purpose of this visit is to meet with Souths Seas and NRHCC, both separately and together, and discuss the COVID-19 Care in Community programme, in particular: the time taken from notification of positive result to clinical and welfare referrals, relationships with local Māori and Pacific providers, and a walk-through of the programme (if time permits).
5. You will be greeted by the Director of Pacific Health (Markerita Poutasi) and the Director of Maori Health (Karl Snowden) for a welcoming Powhiri at 11am.

Recommendations

We recommend you:

a) **Note** the contents of this report.

Robyn Shearer
Deputy Chief Executive,
Sector Support and Infrastructure

Hon Andrew Little
Minister of Health

Meeting advice: Minister Little, South Seas, and Northern Regional Health Coordination Centre

Background / context

1. You are meeting with South Seas and NRHCC at the Pacific and Māori Co-ordination Hubs in East Tamaki, Auckland.
2. NRHCC is the base from which Whānau HQ/Fanau HQ is run, providing care for COVID-19 patients in the community. There are three care pathways for those that require a higher level of support including the Māori Co-ordination Hub, the Pacific Co-ordination Hub and a primary care support pathway delivered by GPs. A hospital in the home programme has also been established to support those requiring a higher level of care at home.
3. South Seas is working with the NRHCC, as a provider of Pacific Healthcare and is considered a trusted partner. Running a local community hub out of Ōtara, including a food hub for the Ministry of Social Development (MSD), South Seas were involved in the design of the model and were one of the first to pilot primary care options in November 2021 together with the Fono. You toured their local facility last year.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

NRHCC

Overview

4. The Pacific Co-ordination Hub and the Māori Co-ordination Hub are located together at 31 Highbrook Drive East Tāmaki.
5. Markerita Poutasi (Director of Pacific Health) and Harriet Paunga (Pacific Hub lead) will be on site along with Karl Snowden (Director of Māori Health) and Kerry Tari (Māori Hub lead).
6. The Pacific Provider Collective and Māori providers have been the mainstay of the Pacific and Māori responses, and are critical to COVID-19 Care in the Community delivery.
7. Although housed within the same Co-ordination Centre, both the Pacific Co-ordination Hub and Māori Co-ordination Hub have different models that are ethnically distinct and tailored for their communities.

Pacific Co ordination Hub

8. The Pacific Co-ordination Hub delivers regional coordination for the seven Pacific clinical providers in the Pacific Collective including: The Fono, South Seas Healthcare, Southpoint Family Doctors, Pasefika Family Health Group, the Tongan Health Society, E Tu Pasifika (formally Mt Wellington Integrated Health Care) and Bader Drive Doctors.
9. Several Pacific clinical providers also deliver social support within the wider social welfare programme, including South Seas.
10. The Pacific Co-ordination Hub has 16 FTE, 6 nurses, 6 social workers and co-ordinators who, in the event of COVID-19, will regionally manage the Pacific positive cases and their

fanau. They will manage the high-risk cases in language and ethnic-specific contexts and the remainder will be moved to either GP options or telehealth.

11. A Pacific MSD group (team of 8) are joining the Pacific Hub shortly. The team has been split in two for Omicron purposes.

12. Referral pathways into the hub will include: automated referrals from positive case notification (CBG currently); hospital in the home; ED, and provider walk ups. All referrals from CBG are currently with a provider within two hours.

13. The Pacific Co-ordination Hub also provides additional triage capability in the event of an omicron surge, providing links to clinical surge capacity from Fanau Ola (CMH); CBG Pacific language clinical teams; the Pacific branch of the GP College and other networks.

14. The Pacific Co-ordination Hub model does not include contact-tracing and is based on a holistic model of care designed by the providers themselves.

Maori Co-ordination

15. This is a regional co-ordination hub for the three Māori clinical providers in the Pacific Collective including: Ngāti Whātua Ōrākei, Whānau Ora and Turuki Healthcare. Additional providers are currently in the process of being on boarded including HealthWEST, Te Hā Oranga, Te Whānau o Waipareira and Te Puna Hauora.

16. The Māori Co-ordination Hub has 21 FTE hub members, including nurses and social workers. Broader welfare support is a key component the hub is working with MSD to ensure appropriate support is provided. The Māori Co-ordination Hub is also working with the Māori Women's Welfare League on potential additional support for children whose carers are affected by COVID-19.

17. Referral pathways into the hub will include: automated referrals from positive case notification (CBG currently); hospital in the home; ED and provider walk-ups. During a surge, the Māori Co-ordination Hub will manage the high-risk cases, medium risk will be moved and GP and provider options, and low risk will be managed by telehealth and self-service. All cases from CBG are referred with two hours.

18. The Māori Co-ordination Hub model does not include contact-tracing and is based on a holistic model of care designed in partnership with providers.

Key Highlights and Challenges

19. Key highlights from the NRHCC delivery model include:

    a. Co-design of a new provider-led service with Māori and Pacific partners, including provider-led delivery of pilot programmes.

    b. Delivery of a holistic, whānau-centred support model that includes welfare provision and acknowledges the Te Whare Tapu Wha Māori health model.

    c. High levels of engagement with the model from Pacific and Māori whānau, reflecting higher levels of trust for provider partners.

    d. Positive family satisfaction and feedback (Moana Research).

    e. Significant improvements in timeframes for response – currently meeting 2-hour referral target for both Māori and Pacific models.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

f. Highly agile approaches and continuous improvement cycle to respond to changing needs on the ground, including developing a new surge approach for Omicron.

20. Key challenges include:

a. Integration at a national, regional, and local level across multiple agencies.

b. Digital interoperability of the pathway; manual pathway options from CBG out to Pacific Co-ordination Hub and the Auckland Regional Public Health Pacific team simultaneously commenced in January 2022. Until that point the referrals had to occur through the Public Health Unit.

Programme for the Day

21. The agenda for your visit is as follows:

Time	Event
11:00am – 11:15am	Welcome and pōwhiri.
11:15am – 11:45pm	Whānau HQ, the Māori Co-ordination Hub and Pacific Co-ordination Hub overview with NRHCC and South Seas, including: • End-to-end process overview (including positive test notification to clinical and welfare referral). • Working relationship with Māori and Pacific providers. Improvements made to date.
11:45pm – 12:15pm	Individual discussions with NRHCC and South Seas.

Equity

22. In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

23. The NRHCC model aims to improve equity across its region.

ENDS.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Document 8

MINISTRY OF HEALTH
MANATŪ HAUORA

Aide-Mémoire

COVID-19 Hospital Readiness

Date due to MO	11 February 2022	**Action required by:**	N/A
Security level:	UNCLASSIFIED	**Health Report number:**	20220205
To:	Hon Andrew Little, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Robyn Shearer	Deputy Chief Executive, Sector Support and Infrastructure	S9(2)(a)
Jess Smaling	Associate Deputy-Director General, DHB Performance and Support	

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Document 8

Aide-Mémoire

COVID-19 Hospital Readiness

Date due:	11 February 2022		
To:	Hon Andrew Little, Minister of Health		
Security level:	UNCLASSIFIED	**Health Report number:**	20220205

Details of meeting: 14 February 2022

Purpose of Meeting: A meeting has been convened by the Prime Minister to discuss COVID-19 Hospital Capacity and Readiness considering Aotearoa's increasing COVID-19 cases.

Comment: This Aide-Mémoire covers the fo lowing topics:

1. Critical Care
2. Acute Demand
3. Planned Care
4. Workforce
5. COVID-19 Care in the Community

Robyn Shearer
Deputy Chief Executive
Sector Support and Infrastructure

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

COVID-19 Hospital Capacity and Readiness

Background

1. District Health Boards (DHBs) and their supporting networks have completed assurance activities to determine the current state of Aotearoa's health sector readiness and considers the country to be highly prepared for Omicron.

2. However, there are challenges to achieving full preparedness. The health sector is unlikely to meet 100% preparedness. Although it has planned for the implications of COVID-19, due to externalities, some of those plans will be unable to be implemented.

3. These externalities were largely present prior to, but exacerbated by, COVID-19. Some examples of these are:

   a. Shortage with a qualified health workforce.

   b. Existing inequities in the health system.

   c. Access to mobile and internet coverage.

   d. Supply chains have become increasingly problematic due to COVID-19 influences, resulting in delays to goods and building supplies. This in turn limits the ability for DHBs to improve existing infrastructure, and purchase required health infrastructure.

DHB COVID-19 Preparedness Reviews

4. As part of its assurance workstream, the Health System Preparedness Programme conducted desktop reviews of 10 DHBs' resurgence plans. The purpose of these reviews was to provide the Ministry with assurance that each DHB had undertaken sufficient preparedness planning to manage COVID-19 cases in their districts.

5. To measure preparedness over time and establish an effective continuous improvement approach to health sector preparedness, baseline data was required. The Ministry designed an assurance checklist to measure COVID-19 preparedness and circulated it to DHB Chief Executives in December 2021.

6. Results of the completed checklist by the 10 DHBs combined identified the following:

   a. 63% of identified preparedness activities were complete.

   b. 36% of identified preparedness activities were partially completed.

   c. 1% of identified preparedness activities were not started.

7. With baseline data and the change in approach due to the emergence of the Omicron variant, an updated checklist was provided to DHBs in January 2022.

8. This updated checklist repeated the requirements identified in the December 2021 checklist, and added a subsequent Omicron specific set of criteria.

9. The results of this checklist identified a national improvement of 10% in completed preparedness activities, presenting a shift to:

   a. 73% of identified preparedness activities to be completed.

   b. 27% of identified preparedness activities to be partially completed.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

10. It is acknowledged that hospitals face considerable systemic and structural challenges, especially in the areas of capacity, facilities and workforce, which existed prior to the onset of the COVID-19 pandemic. The Ministry's Health System Preparedness Programme is working closely with DHBs to identify challenges, share lessons learned and ways to support DHBs to remediate any issues with their COVID-19 preparedness.

11. The desktop reviews and resurgence planning checklists provided the Ministry with a level of assurance that DHBs have plans in place to minimise the impact of COVID-19 on communities within their district.

12. DHBs and their supporting networks have done extensive work to prepare their staff, facilities and communities to address and manage the likely pressures that will come from the increase of COVID-19 in the community. Some of the measures employed include:

    a. working regionally to plan COVID-19 responses

    b. working regionally to share skills

    c. working regionally to share resources

    d. identifying staffing needs and providing training and refresher courses for staff from across the organisations to increase the required workforce.

13. The Ministry is aware that DHBs have identified hospital capacity to be used for COVID-19 positive patient and have plans in place to use capacity and workforce differently as required, should a surge in cases occur.

Critical Care

14. Decisions on prioritising clinical resources and treatment between COVID-19 patients and planned care and other patients is a key role for the health system. Clearly critical patients will always be prioritised first. Unfortunately, this may mean that some services may see ongoing cancellations or delays.

15. There are processes in place to support Intensive Care Unit staff to move around the country if needed. For example, in the early part of the latest outbreak, Intensive Care Unit staff from around the country were identified, with some travelling to Auckland to support the response.

16. This was a pre-emptive strategy to make sure staff had the opportunity to have on the ground orientation – at that stage the size of the outbreak was unknown, and it was prudent to make sure staff were available, trained and orientated; and to mitigate any risk of lower workforce numbers should staff have become close contacts or have been in places of interest. DHBs have had a significant period of pressure with managing Respiratory Syncytial Virus (RSV) patients, so this gave flexibility for rostering and staff welfare.

17. DHBs continue working on ways to increase intensive-care capacity, including using "shelled" spaces (areas of hospitals not currently being used) and converting existing wards to have intensive care capabilities. The Ministry is expecting to approve these plans in the coming weeks.

Surge planning and response

18. Surge planning has included work to ensure we can maximise the use of our current capacity of Intensive Care Unit bed spaces and phase up the use of High Dependency beds, and then Recovery room and other bed spaces.

19. DHBs are working to best balance the demands of health services, related to both COVID-19 and other health needs (such as planned care). However, in an escalated surge situation, there is opportunity to prioritise clinical delivery based on need, and defer non-urgent, deferrable care that may otherwise draw on health system resources, including Intensive Care Unit beds.

20. Hospital bed capacity in Aotearoa changes daily, influenced by district patient demand, hospital resource and staffing. At present, there are approximately:

    a. 250 resourced Critical Care Beds

    b. 180 fully COVID-19 capable beds.

21. In a surge situation, DHBs in Aotearoa can cater for 550 resourced Intensive Care Unit beds, which can also be converted to allow further capacity when required. It is important to note that this is not newly created capacity – it is available capacity being repurposed. As far as capacity is 'surged' for COVID-19 care, the trade-off is capacity for other 'business as usual' health care delivery is being used instead.

22. Not all patients who have COVID-19 may need to be on a ventilator, or in an Intensive Care Unit.

23. DHBs have respiratory equipment for providing a range of oxygen therapies that can be used by respiratory teams outside of Intensive Care Units. These are critical in the management of COVID-19 patients.

Funding for Intensive Care Units' capacity

24. Cabinet has ear-marked $100 million of capital funding from the COVID-19 Response and Recovery Fund to accelerate these ICU projects.

25. The Government will be upgrading 24 local hospitals this year to support planned and routine care, to ensure non-COVID-19 patients are safe when COVID-19 patients are being treated. This includes 23 new Intensive Care Unit and High Dependency Unit beds, and eight temporary bed conversions to Intensive Care Units.

26. The three major Intensive Care Unit capacity-increasing projects – North Shore, Christchurch and Tauranga – remain on target. Tauranga has delivered six High Dependency Unit beds earlier than planned.

27. There is another $544 million of operational funding available over three years to fund ongoing costs like staffing. This funding will be allocated to support additional hospital capacity, including critical care across Aotearoa.

Workforce

28. We have shortages across the range of staff required to support Intensive Care Unit and High Dependency Unit beds. However, currently our greatest limitation is the nursing workforce. The level of capability of hospitals nationally differs, with smaller hospitals not usually providing higher levels of Intensive Care Unit care. Capability is geographically spread, and our staffing reflects this. There are existing networks and processes in place to support transfer of patients as needed.

29. DHBs have and continue to train a range of staff groups who can support experienced Intensive Care Unit staff to manage COVID-19 patients on a temporary basis.

30. COVID-19 funding of $2 million was allocated to fund the Intensive Care Unit support surge training since 2020 - this training builds additional capability for staff to expand their skillset to support patients with higher ventilation needs but are not the same as a fully trained and experienced Intensive Care Unit resource. This also includes those that need refresher training, so is a mix of new and refreshers to boost capacity when needed.

31. This initiative will not necessarily mean the optimal ratio of 1:1 staff: patient ratio would be maintained, but patients would still receive the best care available – in line with the historical high quality of care delivered within Aotearoa's health sector.

32. Work is underway to increase the permanent critical care nursing workforce. An international campaign – aimed predominantly at Aotearoa's trained nurses – has been launched in February 2022. Other funding approved will support post graduate study and increase the number of educators/clinical coaches etc in critical care.

33. The Health System Preparedness programme has funding of $10 million for short to medium term health workforce skills and recruitment initiatives this financial year (to 30 June 2022), of which $3.625 million is designated for the critical care workforce initiatives. These initiatives include the following.

    a. Training for critical care surge support staff - support for the DHBs to train a range of staff who can provide support to experienced critical care staff to care for COVID-19 patients on a short-term basis.

    b. Recruitment co-ordination function – centralised matching and negotiation of packages for staff entering New Zealand, including Managed Isolation and Quarantine places.

    c. Recruitment campaign - support for a DHB led campaign to bring New Zealand trained critical care nurses back.

    d. Educators/clinical coaches to support increased student intake numbers – ensuring that there is increased capability to accept more nurses into critical care study, potentially with more intakes each year.

    e. Scholarship funding for post graduate critical care study -funding for postgraduate study for a critical care paper for 40 nurses.

    f. Funding for increased the Nurse Entry to Practice Programme - increased funding to support 30 additional nurses into critical care roles.

The health workforce is not immune to COVID-19 either. DHBs are reviewing and testing their contingency plans to make sure they have approaches in place should their teams

become unwell (or are identified as close contacts). This includes considering rostering and staff cohorting where possible.

Protecting planned care and maximising the use of critical care capacity

34. Patients requiring complex surgical procedures such as cardiac surgery regularly spend a short time post-surgery in critical care. National plans have been developed to allow the redistribution of patients between units to ensure that the highest priority patients continue to receive timely care.

35. Plans are being developed to ensure that during a surge, all critical care capacity is utilised across Aotearoa in a co-ordinated manner. This will involve patients being transferred as necessary to an appropriate bed space.

Protecting critical care capacity

36. DHBs have increased their capability to manage COVID-19 patients in general (and specialised) wards – focusing on the provision of oxygen to a patient. Within the Delta outbreak to date, this has meant a lower percentage of patients have required critical care than that seen in many other jurisdictions. This is testament to the work of multi-disciplinary teams.

37. The availability of new pharmaceuticals to treat COVID-19 is also impacting the number of patients requiring critical care.

38. Novel therapeutics for COVID-19 that can be used in the community to reduce the risk of hospitalisation, Intensive Care Unit admission and death are in the process of becoming available in New Zealand.[1] Planning is in place to develop implementation plans to rollout these therapeutics in the community, including clear and considered guidance around where their use should be prioritised.

39. Increases in the vaccination rate within the population is positively impacting the number of COVID-19 cases requiring both hospitalisation and critical care.

Acute Demand

40. There is additional work occurring at the primary-secondary interface to strengthen and integrate service delivery to allow primary care to manage people in the community as they become unwell. These people would otherwise need to go to hospital.

    Key points to note are:

    a. This is clinical support for acutely unwell people (as distinct from well or mildly unwell people who are just being monitored).

    b. Many current pathways default to hospital Emergency Departments.

    c. Integrated services can provide support for primary care to treat people in the community and avoid hospital.

---

[1] For example, the Monoclonal Antibody treatment casirivumab/imdevimab (Ronapreve) is currently undergoing the approval process with MedSafe who are awaiting further information from Roche. The initial delivery of 4,800 doses is due to arrive in the country within the next week.

Regarding oral antiviral treatments, the MedSafe approval process for Phizer's oral protease inhibitor is underway and Pharmac's COVID-19 Therapeutic Technical Advisory Group met in late December 2021 to consider the groups that could be eligible for it.

d. Many of these people are COVID-19 positive but will require treatment for non-COVID conditions.

e. The clinical Health Pathways platform used by primary care is updated to include advice, clinical pathways and available options.

41. Options being explored include:

a. Access to community diagnostics (rather than send patients to hospital for x-rays or other tests).

b. Mobile or virtual Mobile Digital Technology community teams (including supporting and upskilling aged residential care staff).

c. Community infusion clinics (for COVID-19 therapeutics, rehydration and other IV needs).

d. 'Hospital in the home' to avoid hospital admission.

e. Virtual ward rounds to provide secondary care while still at home.

f. When admitted to hospital, early discharge with secondary support at home (before being well enough for full discharge back to primary care).

42. Many of these options are already in place in Auckland and worked well during the Delta outbreak. Some other regions have pathways in place for certain acute conditions, but this is not widespread. Work is underway to share these models and provide guidance for DHBs to allow acutely unwell patients to be assessed and managed without the need to go to hospital.

43. With international borders opening and usual seasonal illnesses anticipated to increase over the coming winter months, there is work underway to ensure planning is being carried out for both Omicron and seasonal illness demands on hospital resources.

The winter season planning considers the following:

a. immunisations for flu and measles

b. pharmacy, community and primary care options

c. surveillance monitoring

d. emergency management triggers.

Planned Care

44. The number of Planned Care patients waiting beyond expected timeframes was increasing prior to March 2020 when COVID-19 lockdowns commenced in New Zealand.

45. The shift to the 'Traffic Light' system has enabled DHBs and private hospital providers to continue providing health care services under all 'Traffic Light' colours. This is a significant shift from the Alert Level framework, where many procedures (assessments, diagnostics and surgery) were deferred. Whilst not back to usual planned levels, there has been a marked increase in delivery of Planned Care services in recent months.

46. Ongoing communication is important to ensure our health system continues to deliver as much care as it can safely manage to, and not revert to deferring care unnecessarily.

47. Strategies to optimise capacity include:

a. Additional investment in delivery enabled through COVID-19 Response and Recovery Fund (CRRF), both in public and private facilities.

b. Changes to care models to reduce the demand on hospital services, i.e., use of physiotherapists prior to being accepted for orthopaedic surgery.

48. Advice is provided to the Minister of Health on:

a. the changing quantum of Planned Care impacts in an evolving context

b. the financial impacts of under-delivery of Planned Care

c. other options that could support a reduction in demand or an increase in supply of services.

49. Sector leaders (operational and clinical) meet fortnightly, or more regularly as needed, to discuss emerging service pressures and identify solutions, particularly across tertiary services.

50. Regional collaboration can bring new solutions to resource management. Regional governance leads are focussing this as a priority, and it is anticipated that some of the existing barriers to collaboration can be overcome more readily through the new Health NZ organisation model.

51. Hospitals are no longer able to work in an environment devoid of COVID-19 cases. Planned Care delivery will continue to be disrupted as DHBs maintain protocols to ensure staff and patient safety whilst working in an environment with COVID-19 and non-COVID-19 patients being treated simultaneously.

52. Short term immediate priorities for DHBs are increasing capacity, maintaining stability of and prioritising waiting lists.

COVID-19 Care in the Community

53. Given the likely pace and scale of a widespread Omicron outbreak, the current Care in the Community model will not be able to provide the same high-level of health and welfare support for people required to isolate. To retain capacity for a primary care led intensive clinical care pathway for those with the greatest need, a self-service model has been developed to support low risk patients. This is being built on the following principles:

a. It will be equity focused, ensuring that those with the greatest risk will be able to access the level of clinical care they need.

b. Non-digital support will be available for those who are unable to access digital platforms.

c. Those that can safely self-manage at home will have a range of guidance to enable them to do this, including instructions on how to access emergency assessment should their condition deteriorate at any time.

54. New functionality across key digital platforms that support the delivery of COVID-19 Care in the Community are under active development, with incremental releases expected in the coming weeks. Cases will be able to submit their symptoms, risk factors, welfare needs, and contact tracing information online rather than via phone. We are also looking to embed more text message functionality such as positive cases receiving notification of their test results and information packs with web links via text.

55. A risk stratification tool will allow the health sector to understand its population profiles and manage resources, such as therapeutics and hospitalisation prioritisation, while also ensuring that those who can manage their COVID-19 isolation period independently are enabled to do so. This will free up primary care and hospital level care resources for those who need it the most.

ENDS

Document 9

Briefing

Proposal to resource additional critical care beds across Aotearoa New Zealand

Date due to MO:	28 February 2022	**Action required by:**	N/A
Security level:	IN-CONFIDENCE	**Health Report number:**	20220333
To:	Hon Andrew Little, Minister of Health Hon Grant Robertson, Minister of Finance		

Contact for telephone discussion

Name	Position	Telephone
Robyn Shearer	Deputy Chief Executive, Sector Support and Infrastructure	S9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Proposal to resource additional critical care beds across Aotearoa New Zealand

Security level:	IN CONFIDENCE	**Date:**	28 February 2022
To:	Hon Andrew Little, Minister of Health Hon Grant Robertson, Minister of Finance		

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Purpose of the report

1. This report outlines a proposal to fund additional critical care beds ac oss Aotearoa New Zealand and seeks drawdown of the remaining operating funding set aside in the 'Raising intensive care and inpatient capacity to meet COVID-19 demand' tagged contingency of $542.2 million to increase bed capacity. This operating funding is part of the $544.2 million operating expenditure (and associated $100 million capital expenditure) announced in December 2021.

2. The report details the short, medium and long-term allocation of the funding, acknowledging a shift from the funding of 'surge' (or crisis) capacity to a permanent uplift in capacity.

Summary

3. Since the beginning of the COVID-19 pandemic, district health boards (DHBs) have developed and maintained plans for managing a surge in critical care patients. This has involved identifying areas within their hospitals where patients can be managed, increasing the number of isolation rooms and upgrading airflow, managing stocks of ventilators and key consumables, preparing to defer non-urgent care, and most importantly, training a range of staff who can support experienced critical care personnel to manage patients.

4. Aotearoa NZ currently has approximately 180 adult and paediatric COVID-19 capable Intensive Care (ICU)[1] beds and approximately 260 funded ICU or High Dependency Unit (HDU) beds. Approximately 245 of these beds are resourced. Funding of $140 million on an annual basis will resource an additional 85 (mixture of ICU and HDU) beds.

5. The key limiting factor to resourcing additional critical care beds is the nursing workforce. Funding of $3.6 million (funded through a workforce initiatives allocation) is being applied to supporting a recruitment campaign, increasing funding for training and post graduate study and adding educator/clinical coach time into critical care units across the country through to 30 June 2022.

6. Workforce remains the greatest risk to achieving the increase in capacity over the timeframe indicated. Other work to standardise qualifications and support training will

[1] These are beds that can be resourced on a 24/7, 1:1 nurse:patient ratio, to care for critically ill, ventilated COVID-19 patients on an ongoing basis.

assist in increasing the workforce on a long-term basis. To maintain momentum, funding of $5.3 million will be applied to initiatives to increase the permanent workforce – for recruitment, training and retention – in Year 2.

7. While the focus will remain on the nursing workforce in Years 1 and 2, there is the opportunity to expand the initiatives to other staff groups – predominantly allied health professionals aligned to critical care.

8. In April 2020, the OECD published a report titled "Beyond Containment: Health system responses to COVID-19 in the OECD". Included in this report were comparisons of both intensive care and acute bed numbers across OECD countries. Aotearoa NZ was shown to be particularly low in ICU beds on a population basis.

9. Published in January 2022, the OECD's Economic Survey of NZ again identified the shortage of ICU capacity and included in its first recommendation that this be addressed. This proposal therefore focuses on funding a meaningful uplift in resourced critical care beds across Aotearoa NZ.

10. In November 2021, Cabinet approved the establishment of the 'Raising intensive care and inpatient capacity to meet COVID-19 demand' tagged contingency to fund the operating and capital costs associated with solutions to increase ICU and inpatient bed capacity to meet COVID-19 related pressures on the health system [DEV-21-MIN-0235 refers].

11. In December 2021, funding of $100 million was announced to support rapid hospital improvements to better manage COVID-19, which included the addition of some ICU/HDU beds as well as cardiac care and ward beds. At the same time, $544.2 million was announced to fund increases in hospital bed capacity, both on a surge and permanent basis.

12. Transitioning the funding from surge to permanent as it increases over time allows support for short term peaks in demand to be resourced and also time for the permanent workforce to increase and the additional funded beds to be appropriately resourced.

13. In December 2021, Ministers of Finance and Health (Joint Ministers) approved the drawdown of part of the operating contingency and the full amount of the capital contingency to support a preferred programme of rapid capital investments [HR20212687 refers]. Capital funding of $100 million was drawn down to fund 36 projects of infrastructure upgrades at 24 hospitals across 19 DHBs, with an associated operating funding of $1 million each year in 2021/22 and 2022/23 to meet the cost of a team within the Health Infrastructure Unit of the Ministry to support the completion of the capital projects. The remaining operating balance of the 'Raising intensive care and inpatient capacity to meet COVID-19 demand' tagged contingency is $542.2 million after this drawdown, phased as follows:

$ million	2021/22	2022/23	2023/24	2024/25	2025/26 & Outyears	Total
Operating contingency	15.3	106.3	140.2	140.2	140.2	542.2

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Document 9

14. It is proposed the remaining $542.200 million is allocated as follows:

Year	Funding	One-off	Permanent	Comments
2021/22	$35.3m(1)	$35.3m surge costs	Nil	Spread across regions on activity and population basis to fund surge costs in both critical care and ward beds
2022/23	$86.3m(1)	$5.3m workforce initiatives	$81.0m	Agree timing of new beds on regional basis to apply funding(2)
2023/24	$140.2m	Nil	$140.2m	Permanent uplift of 85 critical care beds(3
Outyears	$140.2m	Nil	$140.2m	Ongoing permanent uplift of 85 critical care beds(3)

(1) In 2021/22 and 2022/23, $1 million has been allocated to departmental expenditure to manage the delivery of the capital fund ($100 million)

(2) Optimally this would be beds resourced from 1 July (but could include others from later dates)

(3) If regions decided to substitute medical ward beds for critical care beds, the total number of beds would increase.

15. Permanent funding would be allocated to regions, with the requirement to resource a minimum number of beds. The baseline for the allocation is the number of beds currently funded at a unit level. The proposed distribution across the country of the 85 additional funded critical care beds is shown at Appendix 1.

16. The expectation is that DHBs would resource existing funded but unresourced beds before accessing any funding through this allocation.

17. From 1 July 2022, the accountability fo this funding will shift to Health NZ (HNZ). The Ministry of Health (the Ministry) will ensure that there is joint governance over the planning and implementation of this funding allocation and that a smooth transition in oversight occurs over the next few months.

Recommendations

	Minister of Health	Minister of Finance

We recommend you:

a) **Note** that on 22 November 2021, Cabinet approved the establishment of the "Raising intensive care and inpatient capacity to meet COVID-19 demand" tagged contingency to fund operating and capital costs associated with solutions to increase ICU and inpatient bed capacity to meet COVID-19-related pressures on the health system [DEV-21-MIN-0235 refers]

b) **Note** that Cabinet authorised the Ministers of Finance and Health to jointly approve the drawdown from this tagged contingency and approve any changes to appropriations subject to the following conditions:

   a. the need for funding is evidenced by reliable and accepted modelling

   b. the solution can realistically be implemented within the short to medium term to reflect the acute need of the COVID-19 response

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Document 9

c. critical enablers (e.g. capital solutions, workforce, logistics, administration) have been provided for and coordinated across the Ministry of Health and applicable District Health Boards (or Health New Zealand regions)

c) **Note** in December 2021, Joint Ministers approved the drawdown of $100 million in capital and $2 million in operating ($1 million each year in 2021/22 and 2022/23) from the "Raising intensive care and inpatient capacity to meet COVID-19 demand" tagged contingency [HR20212687 refers] and the remaining balance of the contingency is $542.2 million in operating funding only, profiled as follows:

$ million	2021/22	2022/23	2023/24	2024/25	2025/26 & Outyears
Operating contingency	15.3	106.3	140.2	140 2	140.2

d) **Agree** the remaining $542.2 million operating funding held in contingency should be rephased across years, to increase funding for surge costs in the 2021/22 year and allocated as follows to fund a minimum of 85 additional inpatient beds: **Yes/No Yes/No**

Year	**Funding**	**One-off**	**Permanent**	**Comments**
2021/22	$35.3m[(1)]	$35.3m surge costs	Nil	Spread across regions on activity and population basis to fund surge costs in both critical care and ward beds
2022/23	$86.3m [1)]	$5.3m workforce initiatives	$81.0m	Surge as above. Agree timing of new beds on regional basis to apply funding[(2)]
2023/24	$140.2m	Nil	$140.2m	Permanent uplift of 85 critical care beds[(3)]
Outyears	$140.2m	Nil	$140.2m	Ongoing permanent uplift of 85 critical care beds[(3)]

(1) In 2021/22 and 2022/23, $1 million has been allocated to departmental expenditure to manage the delivery of the capital fund ($100 million)

(2) Optimally this would be beds resourced from 1 July (but could include others from later dates)

(3) If regions decided to substitute medical ward beds for critical care beds, the total number of beds would increase.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Document 9

e) **Note** the transition in funding from surge funding to permanent funding over Years 1 and 2.

f) **Agree** to fully draw down the remaining $542.2 million from the "Raising intensive care and inpatient capacity to meet COVID-19 demand" tagged contingency to give effect to the policy decision in recommendation d above, exhausting this contingency. **Yes/No** **Yes/No**

g) **Approve** the following changes to appropriations to provide for that decision, with a corresponding impact on the operating balance and net core crown debt: **Yes/No** **Yes/No**

	$m - increase/(decrease)				
Vote: Health **Minister of Health**	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**2025/26 & Outyears**
Non-Departmental Output Expense:					
Health and Disability Support Services - Auckland DHB	4 97				
Health and Disability Support Services - Bay of Plenty DHB	1.54				
Health and Disability Support Services - Canterbury DHB	2.70				
Health and Disability Support Services - Capital & Coast DHB	1.43				
Health and Disability Support Services – Counties-Manukau DHB	6.36				
Health and Disability Support Services - Hawke's Bay DHB	1.02				
Health and Disability Support Services - Hutt Valley DHB	0.77				
Health and Disability Support Services - Lakes DHB	0.67				
Health and Disability Support Services - MidCentral DHB	1.03				
Health and Disability Support Services - Nelson Marlborough DHB	0.89				
Health and Disability Support Services - Northland DHB	1 25				
Health and Disability Support Services - South Canterbury DHB	0.35				
Health and Disability Support Services - Southern DHB	1.74				

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

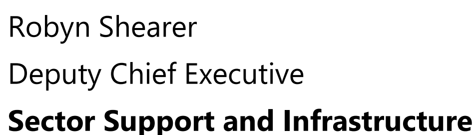
Document 9

Health and Disability Support Services - Tairāwhiti DHB	0.33				
Health and Disability Support Services - Taranaki DHB	0.67				
Health and Disability Support Services - Waikato DHB	2.34				
Health and Disability Support Services - Wairarapa DHB	0 29				
Health and Disability Support Services - Waitematā DHB	6.32				
Health and Disability Support Services - West Coast DHB	0 22				
Health and Disability Support Services - Whanganui DHB	0.43				
Delivering Hospital and Specialist Services	-	86.30	140.20	140.20	140.20
Total Operating	35.30	86.30	140.20	140.20	140.20

h) **Note** that funding in 2022/23 and outyears is being appropriated into the non-departmental output appropriation ***'Delivering Hospital and Specialist Services'*** that has been established as part of the Health and Disability System Reforms from 1 July 2022 [HR 20212335 refers].

i) **Agree** that the changes to appropriations for 2021/22 above be included in the 2021/22 Supplementary Estimates and that, in the interim, the increase be met from Imprest Supply. **Yes/No** **Yes/No**

j) **Note** that quarterly reports will be provided to Ministers on progress towards resourcing additional hospital capacity.



Robyn Shearer
Deputy Chief Executive
Sector Support and Infrastructure

Hon. Andrew Little
Minister of Health
Date:

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Document 9

Date:

Hon Grant Robertson
Minister of Finance
Date:

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Introduction

1. The practice of intensive care medicine (or critical care) involves caring for the sickest and most badly injured patients. As the name implies, it involves concentrated support for each patient, often requiring one-on-one nursing support over extended periods – particularly if the patient needs mechanical ventilation to keep them alive.

2. Critical care is provided in multiple settings, including ICU, HDU and paediatric and neonatal ICU. Critical care staff also provide support to and assessment of patients in hospital wards and co-ordinate and staff the transport of critically ill patients both within and between hospitals.

3. In addition to acute and urgent care, critical care manages a high volume of planned care patients (cardiac and others) who require specialised care immediately after their surgery.

4. In line with other areas of the health sector, critical care is unable to meet the increasing demands of a growing and ageing population, increasing clinical complexity and the improved ability to treat critically ill patients.

5. Over the past ten years (to 2020/21), there have been over 200,000 admissions to critical care units and over 13 million hours of care across adult and paediatric units.

6. In terms of activity through critical care units, the most common diagnoses relate to cardiovascular disease, traumatic injuries, respiratory and digestive diseases and tumours (both malignant and benign).

7. The majority of critical care is provided to patients over the age of 65. In terms of ethnicity, Māori and Pasifika have relatively higher rates of utilisation of critical care – in line with higher rates of admission to hospital generally. This reflects the higher health needs of these groups and is positive from an access perspective.

8. In April 2020, the OECD published a report titled "Beyond Containment: Health system responses to COVID-19 in the OECD". Included in this report were comparisons of both intensive care and acute beds numbers across OECD countries. Comparisons between OECD countries is not exact. Health systems, health funding, bed definitions and counting and models of care are not standardised. However, the data suggests that Aotearoa NZ is particularly low in ICU beds on a population basis. Published in January 2022, the OECD's Economic Survey of NZ again identified the shortage of ICU capacity and included in its first recommendation that this be addressed.

Current context

9. In December 2021, capital expenditure funding of $100 million was announced to support rapid hospital improvements to better manage COVID-19. As part of this funding, 18 permanent and 8 temporary ICU/HDU beds, 5 cardiac care beds and 75 ward beds were to be commissioned.

10. At the same time, $544.2 million was announced to fund increases in hospital bed capacity, both on a surge and permanent basis.

11. Since the beginning of the COVID-19 pandemic, DHBs have developed and maintained plans for managing a surge in critical care patients. This has involved identifying areas

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

within their hospitals where patients can be managed, increasing the number of isolation rooms and upgrading airflow, managing stocks of ventilators and key consumables and most importantly, training a range of staff who can support experienced critical care personnel to manage patients.

12. To support and inform this work, a Critical Care Sector Advisory Group (CCSAG) was established in September 2021 and has been meeting regularly. In addition, during 2021 the Health Infrastructure Unit led a long-term service planning process to identify critical care capacity needs, which also had significant sector and clinical input.

13. This plan provides a robust basis for equitable investment in critical care across Aotearoa NZ – to be co-ordinated on a regional level. The plan is based on ensuring Aotearoa NZ has sufficient ICU/HDU capacity to maintain business as usual (BAU) plus meet future demand based on a growing aging population and the need to improve equitable outcomes. This funding will move the sector towards that goa

Proposal

14. The aim of the funding is to lift the overall capacity of the hospital system, to allow it to continue normal operations and lessen the effects on planned care, while still responding to surges/crises as they occur. It is acknowledged that the increment in capacity enabled by this funding will not eliminate the need for the system to prepare, train and redeploy staff to respond to short term increases in service demand or crises. Winter respiratory illnesses and events such as Whakaari/White Island will always require a specific and targeted response. The Aotearoa NZ health sector has always responded well to these situations.

Link to capital programme ($100 million) to support rapid infrastructure and capacity improvements

15. The 36 projects being funded in hospitals across the country include the development of additional critical care and general ward beds – on both a surge and permanent basis. As these come on-line, they will provide vital surge capacity and also allow improved separation of COVID-19 patients, thereby reducing the risk of cross infection of other patients and staff. This will enable business as usual activity such as planned care procedures to continue at an increased level.

16. These beds will be funded as required on a surge basis from the operating expenditure in Year 1.

17. Unless regions decide to apply funding to general inpatient beds rather than critical care beds, none of the 75 inpatient ward beds nor 5 cardiac care beds being commissioned under the Rapid Hospital Improvement Projects (RHIP) will be directly funded through this allocation.

18. In addition, 16 of the 26 (temporary and permanent) critical care beds being commissioned through the RHIP will not be directly funded. These beds will be available as surge capacity and will be stood up as BAU beds as the population need increases over time.

19. With specific reference to critical care bed capacity across the country, there are already a number of existing beds that are not funded across the country. Long term planning of

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

capacity would suggest that while all beds being added through the RHIP fund will be required in the long term, permanent funding should be applied equitably across all beds – both existing and new. Allocating beds on an equitable basis will require some infrastructure improvements that are not funded via the RHIP. However, confirmation has been obtained that these modifications can be made on the same timeframes, so the beds will be available by 1 July 2023.

Transitioning from surge funding to permanent funding

20. The Ministry has funded DHBs to train staff who can support experienced critical care staff to manage COVID-19 patients. Further funding from this allocation will be utilised in Year 2 to ensure new and refresher training continues.

21. In the short term, the focus for the surge funding in Year 1 will be on ensuring resources can be applied to manage COVID-19 surges within hospitals and supporting the additional staffing costs (backfilling, additional shifts, shifting staff between hospitals) needed to deliver care.

22. Therefore, the proposal includes a rephasing of funding between Years 1 and 2 (supported by Treasury), to account for the expected costs in 2021/22 relating to the Omicron surge. The following table shows the proposed shift in timing for the funding.

Year	Current phasing of funding	Proposed phasing of funding	Comments
2021/22	$15.3m	$35.3m	All funding allocated as surge
2022/23	$106.3m	$86.3m	Mixture of workforce initiatives and permanent funding
2023/24	$140.2m	$140.2m	All funding allocated to permanent uplift
Outyears	$140.2m	$140.2m	All funding allocated to permanent uplift

23. The full funding of $35.3 million in 2021/22 will be available to DHBs on a regional basis to fund surge costs. It is proposed to allocate 50 percent of the funding to the three Auckland metro DHBs, as they have managed (and will continue to manage) the majority of COVID-19 patients requiring hospitalisation and allocate the remaining 50 percent to regions on a population-based funding formula.

24. The COVID-19 financial tracker will be enhanced to capture costs that can be identified for reimbursement from this funding.

25. As COVID-19 evolves to become endemic, preparedness for surges will be managed in the same manner as influenza, RSV, etc and therefore part of a hospital's usual planning processes.

26 The funding in 2022/23 will be a mixture of workforce initiative funding ($5.3 million) and funding ($81 million) for the first allocation of permanent additional beds.

27. The Ministry will work with regions to identify by 30 April 2022, the phasing and timing of the first tranche of additional beds across 2022/23, with a minimum of 45 beds available by 31 December 2022.

28. From 1 July 2023, all funding ($140.2 million) will be allocated to permanent additional beds. The Ministry will work with regions by 30 June 2022 to confirm the final allocation of beds from 1 July 2023.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Focus on critical care (ICU/HDU) beds

29. As previously noted, the OECD report noted NZ as low in both acute beds and critical care beds, but particularly low on the latter.

30. Funding specific increases in general ward beds is more difficult as their staffing and availability is regularly flexed to meet demand and patient acuity. The planning approach used for ICU/HDU needs to also be applied more generally to ward beds, to inform future system wide investment decisions in those areas.

31. As it is proposed that the funding will transition from surge funding to permanent funding from 2023/24 onwards, the surge funding available in the interim periods will be available to be applied across both ICU/HDU and ward beds. Regions will also have the opportunity to switch funding into ward beds if they can justify this as a higher priority.

32. Improving access to ICU/HDU beds also will support improved flow and outcomes across a wide range of hospital services. In particular, in tertiary centres where planned procedures regularly require critical care post-surgery, it has been estimated that around 10 percent of major surgery has been postponed due to lack of an ICU/HDU bed.

33. Applying the full funding (from 2023/24 onwards) to an increment in critical care capacity (ca 85/ca 260 or around 30 percent) will have a greater relative effect than spreading it across ward beds (ca 320/ca 7500 or around 4 percent) due to the relatively high cost of providing critical care beds, their discrete nature, and ease of counting.

34. The need for an increase in critical care capacity was identified well before the pandemic but has received much attention in that light. Whether Omicron or future variants (combined with new treatments etc) result in relatively fewer patients requiring critical care does not eliminate the need for investment in this area.

35. Long term planning suggests a population need of around 400 critical care beds by 2035/36 for business as usual (BAU) activity. This funding – if all applied to critical care – will ensure there is a 50 percent increment towards that number. Making this partial step also allows for a review of the planning before additional beds are added, to reflect update population projections, patient flows and clinical practice changes.

36. In this regard, the Ministry has engaged with interim Health NZ to ensure that this proposal is in line with other long-term planning around location of services, links with tertiary and quaternary services and equity considerations.

Resourcing the additional beds with a focus on nursing workforce

37. Critical care patients require the most complex, intensive and costly care within the health system. A range of staff groups from medical specialists through nursing to allied health and administration are directly involved in the delivery of critical care. Patients also access high volumes of radiology, laboratory services and pharmaceuticals. Maintenance of high-tech equipment requires specialised staff as well.

38. While a number of the staff groups have ongoing shortages, it is deficits in nursing rosters that has resulted in beds remaining unresourced.

39. As part of COVID-19 funding announced in December 2021 for Care in the Community, $10 million was allocated to workforce initiatives with $3.6 million specifically targeted to

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

the critical care nursing workforce. This initiative funding is separate to this proposal, which is to directly resource additional bed capacity.

40. This funding has been allocated for the period to 30 June 2022 to:

   a. Support for the international recruitment campaign launched in February 2022 (the initial campaign being funded by DHBs) – to provide candidate care and liaise with DHBs. This funding also covers an evaluation process to inform future campaigns.
   b. Additional educators and clinical coaches in critical care units across all DHBs – this funding will be allocated on a regional basis.
   c. Additional funding for postgraduate study for nurses completing courses related to critical care.
   d. Initiatives to encourage nurses to choose critical care as a career option.

41. This proposal includes an allocation of $5.3 million in Year 2 to continue the initiatives noted above, as well as seeking other opportunities to support nurses to train in critical care and to potentially expand the initiatives to other staff groups – predominantly allied health professionals – aligned to critical care.

42. Phasing the permanent increase in critical care capacity over the period to 1 July 2023 will allow time for staffing numbers to be increased and therefore beds to be appropriately resourced.

43. Until the allocation of beds across units is finalised and the mix of ICU and HDU beds is known, the total number of additional nurses required to staff them is unclear. It is likely that this number will be 200-300 once all beds are operational. Recruiting to these numbers may affect other services also seeking to recruit and retain staff.

Supporting change with enhanced data collection

44. Historically centrally collected data on critical care activity such as occupancy has been ad hoc and intermittent.

45. As part of ongoing work around both critical care and COVID-19 reporting, the Ministry is mandating the use of the Critical Health Resource Information System (CHRIS), which is run by the Australia and New Zealand Intensive Care Society (ANZICS). Most large (and some smaller) units already provide data into this system on a daily basis.

46. This system has been modified over time to collect data on all hospital COVID-19 patients and ventilator use.

47. As well as providing access by way of personal logins for Ministry staff, a daily extract will be available to be used as a common data source. This will also reduce the need for DHBs to provide manual data, which is prone to human error.

Calculating the cost of a resourced bed

48. To identify the cost of a resourced critical care and general medical ward bed, a data request was sent to DHBs asking them to provide both marginal and fully absorbed costs for the different bed types.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

49. While there was the anticipated range of costs across different levels of critical care beds – relative to the complexity of the patient, the same was not the case for medical ward beds.

50. The range of costs is summarised in the table below.

Critical care bed				
Tertiary DHB	***Low***	***High***	***Average***	
Marginal cost	$1,424,813	$1,521,920	$1,474,831	
Fully absorbed cost	$1,899,750	$2,175,785	$2,015,294	
			$1,745,063	Mid way
Medium DHB				
Marginal cost	$714,810	$1,281,442	$998,297	
Fully absorbed cost	$940,933	$1,601,802	$1,291 418	
			$1,144,858	Mid-way
Small DHB				
Marginal cost	$575,941	$911,337	$755,155	
Fully absorbed cost	$735,638	$1,171,390	$968,561	
			$861,858	Mid-way
Medical ward bed				
	Low	***High***	***Average***	
Marginal cost	$178,779	$443,033	$300,851	
Fully absorbed cost	$235,334	$590,711	$384,383	
			$342,617	Mid-way

51. Based on relative size and populations, the majority of critical care beds will be allocated to medium sized and tertiary (or similarly managed) units. Therefore, the funding allocation has been based on $1.75 million for a tertiary unit and $1.2 million for other units.

52. If a region decides to allocate funding to ward beds rather than critical care, there is an expectation that, based on funding of $350,000 per ward bed, either three or five ward beds would be substituted for a critical care bed.

53. While this funding represents only a marginal increase in the context of overall DHB revenue, directly funding critical care beds allows them to increase resourcing in other areas.

54. Funding critical care units at the higher end of the cost structure will allow them to build capability as well as capacity. Critical care units deliver a range of services in addition to patient care, such as flight co-ordination for patient transfers and outreach services into general wards to support assessment of at-risk patients.

55. Effective and efficient delivery of critical care is dependent on the ability to transfer patients quickly and safely to an appropriate unit. Regions will need to consider this in their deliberations over the location of additional beds. There is a long-term work programme around the future delivery of pre and interhospital transfers and has not been considered as part of this funding.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Allocation of permanent additional beds

56. The proposed allocation is based on the following principles:

    a. The allocation of surge funding in the short term will be applied to hospitals on as 'as needed' basis, with an allocation at a regional level.

    b. The proposal for the permanent allocation of funding will be based on long term service planning – this planning is currently only available for critical care capacity.

    c. The new funding provides the ability to rebase capacity in line with the findings of the national modelling work. Using an allocation based on long term planning addresses existing inequities across regions in the funding of critical care beds.

    d. Allocating the funding at a regional level allows regions to consider their collective capacity and determine a different view of priority investment in their region. This may involve substitution of critical care beds for general ward beds.

    e. The allocation is in line with Health NZ's recognition of and focus on the need to configure capacity more effectively.

57. The long-term service plan for critical care – undertaken by the Health Infrastructure Unit in the Ministry – is based on historical utilisation, patient flows and patient demographics. Using this baseline information, the plan uses population projections, adjusts for such things as increasing length of stay and optimal occupancy rates and projects the need for critical care bed needs at a unit level out to 2035/36.

58. The plan had significant input from critical care clinicians and other stakeholders during its development.

59. While the proposed allocation uses his report as the basis for this interim stepped increase in capacity, there have been some practical adjustments such as not decreasing the number of beds from current capacity.

60. The proposal uses currently funded beds as the baseline – not resourced beds – acknowledging that DHBs have responsibility to resource beds to the level included in their financial planning. Critical care units will not receive their allocated funding until they can confirm that they are able to resource the beds on an ongoing basis.

61. In proposing the allocation, we have engaged with HNZ and they will take leadership of final allocations in 2022/23 and outyears and implementation of this initiative. However, to give assurances around what this funding will achieve, we can confirm that there will be a minimum of 85 additional critical care beds.

62. The Ministry will work with regions to identify the phasing of additional bed capacity during 2022/23 – to ensure the $81 million available in that year is fully utilised.

63. The proposed allocation of beds to be funded on a permanent basis from 1 July 2023 at a facility and regional level is at Appendix A.

Consultation

64. The following groups have been consulted in determining the allocation of this funding:

    a. Interim Health NZ

    b. The Treasury

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

c. The Ministry's Critical Care Sector Advisory Group
d. Other Ministry departments including the Health Infrastructure Unit, Health Workforce, Finance and the Office of the Chief Clinical Officers
e. Regional CE leads on capital expenditure
f. All DHBs receiving funding for additional beds – either critical care or general ward – from the $100 million capital funding.

Challenges, risks and mitigation

Workforce – notably nursing

65. As is the case for all health sector providers currently, the key challenge for critical care is the availability of staff – be that surge support or increasing the permanent workforce.

66. As previously noted, we have funded initiatives targeted at attracting new nurses to critical care, attracting trained nurses to (and back to NZ) and supporting them through their training. DHBs and the Ministry are also cons dering options to support staff retention.

67. Clear communication around funding intentions allows DHBs to commit to recruitment processes across all staff groups.

68. The Ministry will work specifically with DHBs that have a stepped increase in capacity, to ensure they have appropriate plans to resource both staffing and other operating costs as required.

Additional capital funding requirements

69. As a result of the $100 million being specifically targeted to COVID-19 related projects, while the operating expenditure is aimed at equitable capacity increases, a number of DHBs will need additional financial support to allow structural alterations, as well as funding the purcha e of additional beds and related equipment.

70. The Ministry will work with DHBs and (interim) HNZ to ensure that the 85 beds are available by 1 July 2023.

Accountability and monitoring

71. With the health reforms currently being implemented, the responsibility for allocating funding and working with the DHBs to ensure the beds are available and resourced on the timeframes outlined in this paper will shift to HNZ. Similarly, the accountability for maintaining a minimum number of critical care beds and planning for future requirements will belong to HNZ.

72. The Ministry will ensure that there is joint governance over the planning and implementation of this funding allocation and that a smooth transition in oversight occurs over the next few months.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Document 9

Appendix A: Proposed allocation of additional critical care beds

Region	Facility	Currently funded	Share of additional beds	New total
Northern				
	Whangārei	8	1	9
	North Shore / Waitākere	14	4	18
	Auckland CVICU	22	10	32
	Auckland DCCM	17	9	26
	Starship PICU	22	7	29
	Middlemore	18	4	22
		101	***35***	***136***
Te Manawa Taki				
	Tauranga	10	4	14
	Whakatane	4		4
	Rotorua	4	3	7
	Gisborne	3	2	5
	Taranaki	5	1	6
	Waikato	28	1	29
		54	***11***	***65***
Central				
	Wellington	22	9	31
	Hawke's Bay	11	3	14
	Hutt	4	2	6
	Palmerston North	6	1	7
	Wairarapa	6		6
	Whanganui	3		3
		52	***15***	***67***
South Island				
	Christchurch	21	12	33
	Nelson	7		7
	Wairau	4		4
	Timaru	4	2	6
	Dunedin	9	10	19
	Southland	6		6
	Greymouth	4		4
		55	***24***	***79***
Total		**262**	**85**	**347**

NB: additional physical beds – 4 at Waitematā, 3 at Counties Manukau, 2 at Bay of Plenty, 9 at Canterbury and 2 at Nelson Marlborough – are held as surge capacity and for long term need.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Document 10

MINISTRY OF HEALTH
MANATŪ HAUORA

Aide-Mémoire

Visit to Waikato District Health Board

Date due to MO:	21 March 2022	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20220505
To:	Hon Andrew Little, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Jess Smaling	Acting Deputy Director-General, DHB Performance and Support	S9(2)(a)
Stuart Powell	Chief Advisor, DHB Performance and Support	

Document 10

MINISTRY OF HEALTH
MANATŪ HAUORA

Aide-Mémoire

Visit to Waikato District Health Board

Date due:	21 March 2022		
To:	Hon Andrew Little, Minister of Health		
Security level:	IN CONFIDENCE	**Health Report number:**	20220505

Details of the visit

Tuesday 22 March 2022

8.00am-9.30am

Waikato Hospital
183 Pembroke Street
Hamilton

Organisation

Waikato District Health Board (DHB) serves a population of more than 425,000 and covers more than 21,000 km^2. It stretches from northern Coromandel to Mt Ruapehu in the south, and from Raglan on the west coast to Waihi on the east. Fifty-nine percent of the population is defined as living in urban areas, and 41 percent in rural areas. Twenty-three percent of the population is Māori (compared to the national average of 16 percent).

Purpose of the visit

On Tuesday 22 March, you are visiting Waikato DHB to meet with frontline staff and senior staff leading Waikato DHB's COVID-19 response S9(2)(c)

Comment:

You will be accompanied by a staff member from your office. As per the COVID-19 protocols only one staff member will be allowed to visit the premises with you.

A run sheet for the visit is provided in Appendix One.

This aide-mémoire discloses all relevant information.

Jess Smaling
Acting Deputy Director-General
DHB Performance and Support

Document 10

Briefing points to support your visit

1. This briefing will support your visit to Waikato DHB. This is a follow-on from your visit on 17 December 2021 (HR 20212734 refers). It provides an opportunity to observe on the ground pressures to respond to COVID-19 and S9(2)(c)

2. During the visit you may like to:

   a. *Thank the people you meet for their ongoing mahi and their resilience.*

Waikato District Health Board

3. Dame Karen Poutasi has been Commissioner at the DHB since May 2019, when then Minister of Health, Hon Dr David Clark, ordered the replacement of the Board. Dame Karen works with two Deputy Commissioners, Chad Paraone and Emeritus Professor Margaret Wilson. Mr Ken Whelan was appointed to the role of Crown Monitor at Waikato DHB in August 2018, and the appointment was extended in February 2021 to an open-ended term.

4. Waikato DHB's YTD results for the eight months ended 28 February 2022 is a deficit of $5.3 million against a YTD budgeted deficit of $8.5 million. The underlying BAU deficit net of Covid-19 surpluses and the impact of uninsured cyber-attack costs is a net deficit of $9.8 million. The DHB is forecasting to end the current financial year with a net deficit well below its budgeted deficit of $30 million (BAU).

5. Waikato DHB has five infrastructure projects with approved Crown funding totalling $111 million. The Wairora building seismic upgrade and Farmers building projects are classified S9(2)(f)(iv) by the Health Infrastructure Unit (HIU) and are on track. The Linear Accelerators, Tokoroa Hospital reconfiguration and Adult Mental Health Facility projects are classified as S9(2)(f)(iv) by the HIU and risk mitigations are in place. A business case for the Linear Accelerators was received in January 2022 and a Health Report is being prepared for the Director-General of Health's approval. A concept plan was agreed in December 2021 for the Tokoroa Hospital reconfiguration and project deliverables have been established. The DHB is preparing the Adult Mental Health Facility detailed business case and is on track for the Capital Investment Committee consideration in the April 2022 meeting.

6. The Waikato DHB 2021/22 Annual Plan was signed by joint Ministers on 30 September 2021.

7. A summary of key service performance indicators for Waikato DHB shows the following:

   - As of 13 March 2022, the cardiac waiting list is within the total maximum waiting with 64 patients listed for surgery (total maximum waiting target 75). 13 out of 64 patients are waiting outside their expected treatment timeframes.
   - Emergency Department (ED) - 67.1 percent of patients (target 95 percent) are being admitted, discharged or transferred within six hours. The DHB has been below 70 percent for most of the last two quarters of 2021.
   - Planned Care Interventions are at 100.0 percent delivery against plan with 93.9 percent inpatient surgical discharges and 96.3 percent caseweights.

- ESPI 2 - 22 services are not meeting ESPI 2 (First Specialist Assessment) expectations, with 4,252 patients waiting longer than four months.
- ESPI 5 - 15 services are not meeting ESPI 5 (Treatment) expectations, with 2,054 patients waiting longer than four months.
- CT performance - 69.4 percent of patients waiting less than six weeks for their scan against a 95 percent target. The DHB has been below target the last 12 months.
- MRI performance - 61.5 percent of patients waiting less than six weeks for their scan against a 90 percent target. The DHB has been below target the last 12 months.
- Improvement Action Plan (IAP) Funding - Waikato DHB have an approved IAP which is addressing part of the waiting lists in orthopaedics, improving waiting list management, and the commencement of extra clinics on weekends to reduce long waiters.

8. You may like to take the opportunity to:

   a. Thank them for achieving 96% of expected Planned Care caseweighted discharges in this extremely challenging environment.

   b. Discuss the challenges of ensuring patients that need to be seen or treated urgently continue to receive their services whilst dealing with the Omicron surge.

9. The DHB has been part of the Ministry of Health's (the Ministry) Intensive Support Programme since April 2021 and is progressing an intensive support plan which covers the following areas:

   - Mental Health and Addictions Implementation programme in response to the recently completed 'Waikato Mental Health and Addictions System Review'.
   - Reduction of child and adolescent mental health services waiting times.
   - Financial sustainability initiatives.
   - Development of more integrated community and primary care services.

COVID-19 Response

10. Across the Te Manawa Taki Region (Waikato DHB, Taranaki DHB, Lakes DHB, Bay of Plenty DHB and Tairawhiti DHB) all the five DHBs have worked well via their Care in Community hubs to support people and their whānau with COVID-19 and to ensure an equitable response.

11. The region reports workforce and capacity as their primary pressure point. This is due to staffing shortages, increase in sick leave being taken, inability to recruit and to staff leaving due to workload pressures noted as a factor. The workforce issue is raised across the full continuum of care – primary care, hospital services, vaccination and testing programmes, older persons care, disability support services, pharmacy and mental health and addiction services.

12. The region also expressed concern that the initial Self-Assessment form that COVID-positive patients are asked to fill out is too long and will further compound equity issues. The Ministry at the beginning of March 2022 reduced the length of the form which now takes on average five-ten minutes to fill out. Continuous improvements are being done to make the form more user friendly.

13. In addition, the region is concerned about the roll out, implementation, training and delivery timeframes of the data and digital space. The upgrades were difficult to keep up with and created a lot of manual work in-between the changes. The concern was that whānau may 'fall through the cracks'. In response to these concerns the Ministry has:
    - A team dedicated to support the implementation of the data and digital solutions available for care providers and the community care hubs. The team provides a range of drop-in sessions for end users and hubs, regional education sessions, GP-specific education and regular updates on data and digital changes and upcoming enhancements.
    - Conducted a review of all the hubs to ascertain their level of preparedness, take learnings from other hubs and align possible regional and localised solutions.
    - Conducted several sessions to address issues relating to technology access and reporting needs.
    - Recruited four Regional Health Liaisons who coordinate the preparedness and operations of the response, share lessons learned and continually review and streamline processes.
14. RATs collection sites and provider channels are enabling at least 94.8% of the population to access RATs within a 20 minute drive.
15. RATs are being provided into the Waikato community via the collection sites and Tainui Waikato is providing a parallel channel into community providers and their communities. Tainui Waikato is part of a National Māori Provider Distribution Channel supporting the distribution of RATs to Māori and vulnerable communities. The Ministry stood this up three weeks ago to advance equitable access for Māori and prioritised populations.
16. Pacific Health & Disability Providers now have access through several channels to order supply of RATS and PPE from the Ministry and pull from the DHB's and the Māori Providers Distribution Channels.
17. PPE supply has suffered from the domestic freight and courier challenges due to absenteeism caused by the outbreak. Recent feedback to the Ministry is that PPE is flowing into the providers.
18. Throughout the visit you may like to take the opportunity to *ask:*
    a. *What are the things that are working well, that we absolutely need to continue doing, and what are the things that are working less well, that we need to resolve?*
19. Throughout the visit you may like to comment that:
    a. *People are working in an extremely dynamic and demanding environment and that you recognise the challenges that places on, not just them and their colleagues, but also their loved ones and wider whānau.*
    b. *You acknowledge staff fatigue at this time and thank staff who have stepped up to fill some of the critical roles.*

Document 10

COVID-19 Situation Update

20. As of 20 March 2022, Waikato DHB reports[1]

    a. 1339 new community cases

    b. 10,449 active cases

    c. 93.5% of the population is fully vaccinated

    d. 68.6% of the population aged 18 and over has received a booster dose

    e. 83 cases are in the hospital

    f. 4 cases are in ICU/HDU

[1] https://www.waikatodhbnewsroom.co.nz/2022/03/20/covid-19-public-advisory-20-march-2022/

S9(2)(c)

25. You may like to take the opportunity to ask:

    a. *If there are any ongoing clinical and operational challenges they face after resuming normal operations?*

26. You may like to take the opportunity to:

    a. *Thank them for progressing the remediation programme in this challenging environment.*

    b. *Thank staff for their effort during the incident and continuing to provide services to the community and the Te Manawa Taki region.*

END.

Document 10